			-	State of Maryland /	Departm		ealth and M	ental Hy		0.5	155	ΠΙ
	Physici /Medic		1. Decedent's Name (First, Middle, Last) A 1 TO Defeo					2. Date of De Month May		2005	3. Time of 1	Death A M
	Examin		4a. Facility Name (If not institution, give str Keswick Home		Ba	City, Town, or ltimore Under 1 Year	Location of Death	O Date of Bio	N/A	nty of Death	(O)	
	Funeral Director		5. Social Security Number 169-01-6439 Usual Residence of Decedent	7. Age (In yrs. last bi		nths Days	Hours Min.	8. Date of Bir (Month, Da FeD • 9	, 1911	Penn	ace (State or try) Sylvan	ia
	e Maryland Ba-f show	Director	MD Baltimore	10c. City, Tov					<u> </u>		0d. Inside Cit	
	th with the 23a or 2 and 151 Le a		514 Stevenson Lane			of. Zip Code 21286			USA	of What Coun	try?	
036	hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examiner must be multied at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		Decedent of His , specify Cubar es 2 No	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No Rican, etc.))- 14. F Spe	Race - Americ Black, White, cify: Whi	etc.	
1215-0	d within 72 ho giene. ir than "natur ir e M. alcal	Completed by	15. Decedent's Educa (Specify onfy highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	a. Decedent's (Give kind life. DO N		tion uring most of workii	ng	16b. Kind of	Business/Ind	lustry	
Maryland 21215-0036	be filed stal Hygi ed other evant, I	To Be Co	17. Father's Name (First, Middle, Last) Thomas C. Birt		nemake		18. Mother's Name Amelia P		, Maiden Sum			
	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Types Joan Dyer / n				nd Number or Aura Ourt; Oak				Code)	
Baltimore,	Pages 1 an ment of Heal tant: if itam 2 jury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		of Disposition ery, cremator and Mei	(Name of y or other place morial	5/9/05	ate	20c. Location	n - City or To		
Balti	permit. Departm Imports any inju		21. Signature of Fureral Service Usensee	lux	Ruck		Funeral	Home	1050 Tows	York on, MD	Road	ŀ
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause a sach line.	not enter the	mode of dying	, such as cardiac o	r respiratory a	rrest,	, 3	Approximate Interval Betw Onset and D	veen Death
3760,	Medical Examiner hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying that initiated events resulting in death) Last c.	Due to (or as a consequence	AL a of):	ARR	usion	legen	ft d	3	Fela	φ 2
P.O. Box 68	The law requires that the death certificate tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	t. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		opic pregnancy er (specify)	-			Date of delive	•	/ear
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contr	ibuting to death but not resulting	in the underly	ying cause give	n in Part I.		obacco use c Yes 2 2 No		e cause of de ably 4 □U	
I Records,		Completed						24a. Was auto perfo 1 Yes	psy ormed?	death?	osy findings a npletion of ca 2 No	available ause of
Vital	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3	□ DOA Othe	26. Place of Death			Other (Specifi	·)	
ion of	After After funer	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	Time of Injury	28c. Injury Work		28d. Describe			,	
Division	i Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, f	actory, office	2	28f. Location (City or To		mber or Rura	l Route Numb	ber,
	tha Hospital hin 24 hours a tha Funaral I npletely filled	Medical	29a. Certifier (Check only one) Certifying Physic Medicel Examine	r: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occi ind/or investig	urred at the tim- gation, in my op	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s))
	To tha within 2 vithin 2 to tha f	Me	29b. Signature and title of certifier	I Prive,		29c. License	number 2233°	1	29d. Date sig	ned (Month,	Day, Year)	_
į	×		30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)	th SK	reet /	Sulti	Ture	71	2/(
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's signature 9 2005	, H.	Goods	,					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** APril 23, Jane H. Doss 2005 5:15 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Broadmeade Cockeysville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 22, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 216-52-5394 81 Yrs. Director 1923 Georgia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? 13801 York Road #Q-12 "natural", or Items 23a 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) dietitian DC welfare system permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horatio Harrell Caroline Herring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Doss/spouse 13801 York Road #0-12 Cockeysville, ND 21030 of Disposition (Name of 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature or substance of the season of Approximate Interval Between Onset and Death Immediate Callise (F disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ⊒Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital/Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 12 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No funeral dir Medical Certification: To 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending thours after death, uneral Director: After the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) Name and address of person who completed cause of death (Item 23a) (Type. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

hris	tine Da	vi	State of Maryland / De	partment of Health and North Research	Mental Hygier tas	ie
	Physici /Medic		1 Decedent's Name (First, Middle, Last)	vis	2. Date of Death Month	Day Year 3. Time of Death 3
	Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.		Baltimore City
3	Funeral Director		330-74-7 56 1□ M 2ØF 45 Yr Usual Residence of Decedent	s. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Mary) and
	ith the Marylan or 28a-f show as notified at	Director	MD NA Baltim	ore		10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	sath with ti is 23a or 2 must be n	eral Dire	10e. Street and Number 1524 Barclay St. 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 2/32/	us	Citizen of What Country?
920	ours after de rai', or item Examiner of	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerton 1 Yes 2 No Specify: 	o Rican, etc.)	Black, White, etc. Specify: Black
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Completed	(Specify only highest grade completed) (0	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired FORDER COOK	king	Kind of Business/Industry lendys Restaurant
Maryland 2	should be filed nd Mental Hygin marked other amatic event, t	To Be Co	17. Father's Name (First, Middle, Last) Clarence Davis		ne (First, Middle, Maid	
	s 1 and 2 shou I Health and N Item 27 is ma ther traumal		Amanda Davis - Manning-Sister 390		10. MD 21	306
Baltimore,	t. Partmer		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify)		Date 20c.	Location - City or Town, State
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	Physician /Medical		shock, or Meant failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methadone Intoxio Due to (or as a consequence of	cation		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events c			
Box 687	The law requires that the death certificate be site has been signed by the attending physicis bage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1	3 ☐Ectopic pregnancy		23d. Date of delivery
P.O. B	es that the death cer igned by the attendin be detached for use	Physicia	1 Yes 2 No 9 Unknown	5 Other (specify)	One Didaster	Month Day Year
ords,	w requires the been signer should be d	þ	Part II. Other significant conditions contributing to death but not resulting in II. Hypertensive Cardiovascular Disease	ne underlying cause given in Part I.	1 Tes	
tal Rec	sician: The law certificate has l rector, page 2 s	e Completed	25. Was case referred to medical	OO Disse of Day	24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
Division of Vital Records,	hys this al di	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fe/Outp 27. Manner of Death 1 Natural 5 Pending Pound: 1 Natural 5 Pending Found: 2	Other	lome 5 Residence 28d. Describe how in	11957
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	2 Accident 3 Suicide 4 Homicide Could not be determined Example 1 Accident 5 3 - 3 - 0 5 28e. Place of Injury - At home, farm building, etc. (Specify) Found in residen	n, street, factory, office	281. Location (Street City or Town, St. Baltimore	and Number of Bural Baute Number, ate) 1529 Barclay St.
	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medicel Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.
	To t with To t	Σ	29b. Signature of title of certifier What Hallan We	29c. License number OCME		Date signed <i>(Month, Day, Year)</i> May,4,2005
	-01		30. Name and address of person who completed cause of death (Item 23a) (T A 31. Date filled (Month, Day, Year) 32. Registrar's Signature		Baltimore	e, Maryland 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 2005 32 Registrar's Signature	gove -		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Decarlo Month Year **Physician** PM Agnes 1:16 2005 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 102 27 1934 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 9790 Months 28 1 □ M 2 1 F 70 Director June MAM Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at Dundalk 1 TYes 2 No Baltimore Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 States Ra United JACKSOM 1702 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or iten eny injury or other treumatic event, the Medical Examinar once. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homem aker OWN 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Schultze Agnes Heinlein trnes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1702 JACKSON Rd. Dundalk MD. 21222 Raymond DeCarlo Spovse 1702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MAY 7 2005 BAltmore BAYVIEW Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connell Tyneral Ho 21. Signature of Funeral Service Licensee Pulate, MD. Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to as a consequence of): disease or condition resulting in death) brain injury /Medical Examiner stroke Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit The taw requires that the death certiticate be executed Intraventricular that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Intra parenchymal homorrhage IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructive pulmonary 3 Probably 4 Wiknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 😉 No 1 Yes 1 Tes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours atter death.

To the Funerei Director: Atter th
completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of puttle 29c. License number 34122 May 6 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21224 4940 Eastern Avenue, sweet 31. Date filed (Month, Day, Yea MAY 0 Registrar's Signal e State Magistral's Registrar

		1 - For State Registrar	State of Maryland	-	artment of H				
		Decedent's Name (First, Middle, Last)			imouto of L	J04.17	2. Date of Death	No. 0 0 (3. Time of Death
Physicia	_	Francis S.	Davenpo	rt			Month	Day Ye	
/Medic		4a, Facility Name (If not institution, give st		1.0	4b. City. Town. or	Location of Death	10/an	4c. County of D	
Examin	er	No. H O I - I N	100 - 101		Glen R) ()
Fundament		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	HUUG 1	Birthplace (State or Foreign
Funeral Director			M 2□F 5		Months Days	Hours Min.	Nov. 24,	953	Country) MD
		Usual Residence of Decedent					11011213	,,,,,,	
ylanc now		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Mar F	to	MD Anne Aru	ndel G	len Bu	ırnie				1 ☐ Yes 2 ☐ No
r 284	irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	t Country?
h wit	O E	1000 Lee Road			21061			U.S.A.	
deat ms 2	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S		Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		American Indian,
after or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	1	f Yes, specify Cuba		Hican, etc.)	Black, V	White, etc.
Pari, and	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2∏XNo	Specify:		Specify:	white
72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa	ation	16	b. Kind of Busine	ess/Industry
1 ig i i i i i i i i i i i i i i i i i i	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o OO NOT use retired,)	9		
ed w	S	12		Mair	itenance			BG&E E1	ectric
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or items 23a or 28a-f show event, the Medical Evant are missible inclities at	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma		
should nd Men of marke	၉	Frank Sharpless	•				erine Lou		
2 sh and is m		19a. Informant's Name/Relationship (Typ	e, Print) attorney	19b. Mailin	g Address (Street a	and Number or Rura	al Route Number, C	ity or Town, Sta	te, Zip Code)
and and ealth m 27		Mr. William Schere					, Glen Bu		
Peges 1 nent of Ho nt: Miter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, cren	sition (Name of natory or other place	9)		c. Location - City	y or Town, State
Peg ment ent:		*4 □ Donation 5 □ Other (Specify)	Gle		en Mem. Pa	1		en Burn	
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Health and House 28a or 28a - 1 show any injury or other traumatic event, the Medical Examt are must be inclitted at some.		21. Signature of Foneral Service License	on.	22	. Name and Addres	s of Facility Sin	gleton Fu	neral	Home P.A.
207799		Christmer Co	Dulling MOI	319 1	Second A	venue S.W	.,Glen Bu	rnie, M	ம் 21061
1 1 1 1 1		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that cau the death. e cause on each line.	Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Anexic ,	ONTE	obolo	milhe	1		Onset and Death
/Medical		resulting in death)	Due to (or as a conseque	ence of):	7. 200	1	10		110013
Examiner		Sequentially list conditions b.	Ischem	16	Cordi	DMUS	athur		Bears
ס ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
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ath cer	lan/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnan	death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dea 9 Unknown	ath 5□	Other (specify)			Worter	Day
hat the d by letac	Phy	Part II. Other significant conditions cont	ributing to double but not you.	isin — in also		in Death	200 Didasha		
ires that the death cer signed by the ettendin d be detached for use	by	ratti. Ottor significant conditions con	mouning to death but not resul	ung in trie ur	idenying cause give	en in Part I.			te to the cause of death?
w requir been si should	Completed						1 105	2 □ No 3 🔀	Probably 4 Unknown
law law last e 2 s	nple						24a. Was an autopsy	24b. Were	e autopsy findings available to completion of cause of
The Date	Co						performe 1 ☐ Yes 2 🗸	d? deat	h? 🛂
ding Physicien: The law h. After this certificate has t funeral director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Death	Check on one		
hysi this o	ို	10103 2 410	1	R/Outpatien	t 3 DOA Othe	4 Nursing Ho	me 5 Residenc	e 6 Other (5	Specify)
ding Phys	on	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time <i>o</i> f Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
r Attend er death rector: A	cati	2 Accident investigation 3 Suicide 6 Could not be				res 2□No			
or At fter d lirect n by	ertification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	t and Number of State)	r Rural Route Number,
pitei urs a arei E	O	00.00							
Hos 24 ho Fun Fun tely f	lica	[Check Gray E Medical Examin	er: On the basis of examination	rledge, death on and/ <i>o</i> r inv	occurred at the time restigation, in my op	e, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funesial Director: After this certificate has been signed by the ettending prompletely filled in by the funeral director. page 2 should be detached for use as	Medical	29b. Signature and title of certifier	and manner stated.		29c. License				
FIFO	-	Sold distribution of control	0 110		TO A	2771	1 1	A. I II	Ionth, Day, Year)
17		Mull Xalli	U FIU		900	Daly	7 1	My 7	2000
2		30. Name and address of person who con		23a) (Type, I	Print)	(-la	Rich	O M	D 2101-1
» Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	TUXP	1101 0	Y GIE	1 DUIT	C 1-1	1) X1001
Registr		MAY 0 9 200	Les de						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

						,	(Certifi	cate of	Death	,	Reg. No. 2	105	12	: 0 /
	Dhysisia		1. Decedent's Name (First,	Middle, La	st)		7	/			2. Date of De	eath Dey	Year	3. Time	of Death
No. of	Physicia /Medic		Lorella				100	an			May	5 2	2005	14:	45
	Examin	er	4a Fecility Name (If not ins	titution, giv	e street end numbe	or) //	(3			4b. City, Town, or	Location of Deat			/	
			Cromwell	No	ersing/	1-100	ne	161	Index 4 Year	Balti	more		TIMOR		
Sec.	Funeral Director		5. Social Security Number 213-10-9083 Usual Residence of Deced		Sex I□ M 225 B	Age (In yrs. 87			Inder 1 Year oths Days		. (Month, Da	th ay, Year) 0/1917	9. Birthpi Coun VIR	lace (Stete try) GINIA	or Foreign
	yand wa		10a. State 10b. 0			10c. Cit	ty, Town	or Location	1				10	Od. Inside (City Limits
	he Mary 28a-f sh offfied	ector		LTIMO	RE		TOWS								s 2 🛣 No
	ath with t	Funeral Director	10e. Street end Number 8356 LOCH R	AVEN	BLVD.				f. Zip Code 2128			10g. Citizen of US		lry?	
020	urs a	2	11. Marital Status 1 Never Married 2 3 □ Widowed 4 □ Div		12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? ∛∐No	,S.			Hispanic Origin? (pan, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specif	ce - America ck, White, e		0
5-0	72 h	etec	15. De (Specify only	cedent's Ed	ducation ade completed)		1 1	Give kind	Usual Occu	during most of we	orkina	16b. Kind of B			
21215-0020	d within giene. rr than	Completed	Elementary/Secondary (I		College (1-4c	or 5+)	1	CRET	OT use retire	od)	•	COMMU	NITY	CREDI	T.
Maryland	should be filed with ind Mental Hygiene. I marked other than umatic event, the	o Be	17. Fether's Name (First, MC VINCENT							18. Mother's Na ELLEN	ame (First, Middle CRAIG	, Maiden Sumar	me)		
ary	2 shoul and Ma la mark	F	19a. Informant's Name/Re	ationship (Type, Print)		19b. I	Mailing Ad	dress (Stree	t and Number or F	îurel Route Numb	er, City or Town	, State, Zip	Code)	
ž	C = O -	ı	LOUISE THOMP	SON/S	ISTER					VEN BLVD		N, MD		,	
Baltimore,	ages ent of it: if it		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot	ation 3 🗆	Removal from Sta	20b. F	Place of I	Dienneition	(Name of	ice)	Date 5/10/05	20c. Location	- City or To)
Balt	parmit. Pag Department Important: any injury o		21. Signature of Funeral Sc	ervice Licer	1500			22. Nan	e and Addre		THE JOHN	SON FUN			P.A.
		\dashv	23a. Part1. Enter the diseashock, or heart failure	se, or com	plications that caus	ed the deat	h. Do no					•		Approxima	ate
1. A	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. List only						ymia			1	Interval Be Onset and	i Death
		- e				Due to (d	or as a co	nsequenc	9 9K:						
	artificate be assecuted ing physician and a as the bunal-transit	Examiner	Sequentially list conditions		b	Due to (c	or es a co	nsequence	of).				1		
oʻ	an an inal-tr	EX	Sequentially list conditions if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			24010 (0		nooquono					1		
68760,	certificate be axecuted nding physician and usa as the bunal-transit	edicai	Cause (Disease or injury that initieted events resulting in death) Last	1	C	Due to (o	rasaco	nsequence	of):				-		
39 ×	ng pt a as t	Med	resulting in death, Last	L									l I		
8	eath cer attandin I for usa	an			d								1		
	0 0 0	Physician/	Part II. Other significant co	nditions o	ontributing to death	but not res	ulting in t	he underly	ing cause gi	ven in Part I.	23b. Did	tobecco use co	ntribute to	the cause	of death?
s, P.O		by Phy	End sta	le e	+ Res	reck	0	Sei	use.	•	1 🗆	Yes 2□ No	3 🗆 Prob	ably 4 🖸	nknown
Records,	law raquira as bean sig a 2 should t	Completed	C. diff	CO C	45						24a. Was	an autopsy rmed?	ava	re autopsy ilable prior npletion of leath?	to
œ —	The la	E	4							,	101	Yes 2000	1 🗆	Yes 2	∃ No
Vital	ectifical rector, p	Be	25. Was case referred to mexaminer?	edical						26. Plage of De	ath (Check only o	one)			
of C	S 50	0	1 ☐ Yes 2 ☑ No		Hospital: 1 Inpa		ER/Outp	atient 3[DOA Oti	ner: 4 Nursing I	Home 5 □ Resid	dence 6 □Oth	ner (Specify)	
	Attanding Ph r death. octor: After th by the funeral			ending vestigation	28e. Date of In (Month, £	jury Jey Year)	28b. Tin Inju		28c. Inju Wo 1 [ryat rk? ∣Yes 2 □ No	28d. Describe	how injury occur	red		
Division	To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 6 4 Homicide	could not be letermined	289. Place of I	njury - At ho etc. (Specify	ome, farm	n, street, fa	ctory, office		28f. Location (City or Tox	Street and Numb vn, State)	ber or Rural	Route Nur	mber,
	ne Hospital n 24 hours a	edicai	29a. Certifier 1 Ce (Check only 2 Me	rtifying Ph dical Exam	ysician: To the bes niner: On the basis and manners	of examina	wledge, o	leath occu or investig	rred at the til ation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and made date and place,	anner as sta and due to	ited. the cause((s)
	vithii To th	Σ	29b. Signature and title of o	ertifier					29c. Licens	se number		29d. Date signe	d (Month, E	ay, Year)	
	1		1 (471)	flo?		MI		D-!- '	Doc	59855		May	5,2	005	
	4		Qinglin	Cia		560	16	rpe, Print)	Ran	19853 1201 Bl	vol, Bo	Atimo	nl,	MDa	21093
0,	Stat		31. Date filed (Month, Day,	rear) Q 2∩∩i	. Regis	trar's Signa	ture	hard	,						

			1 = For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artme rtifica	nt of He te of D	ealth an Death	d Me	ntal Hy	/giene Reg. No	Title Car Co.	5	1550
	hysicia		Decedent's Name (First, Middle, Claude B. D								Date of D Month April	Da	y Yes	ar .	3. Time of Death 4:30 AM M
	Medic xamin		4a. Facility Name (If not institution,				4b. Cit	y, Town, or	Location of D				. County of D	eath	
		ш	1848 Genera	ls Highw	ay			Annapo	lis			A	Anne Ai	cund	le1
	neral ector		5. Social Security Number 212–28–6382	6. Sex 1∭2 M 2□ F	7. Age (In yrs. 74	last birthday) Yrs.	If Und Month	er 1 Year s Days	Hours N	Min.	Date of B (Month, D	irth <i>ay, Year)</i> 193	9. 1 M		nce (State or Foreign y) 1and
<u>و</u> .	17000		Usual Residence of Decedent		10-0										
aryla	III I	-	MD Anne	Arundel		ty, Town or Lo Annapo1								10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
Pe M	all line	ecto				mapor		r 0. d.				10. 0			
with t	2	늄	10e. Street and Number 1848 Generals	Highway			107. 2	Zip Code 2 1	L401			10g. Cii	tizen of What USA	Countr	у?
eath		era	11. Marital Status		ecedent Ever in U	IS 13 1	Was Dec		panic Origin	? (Specif	fy Yas or N	<u></u>	14. Race - A	merica	n Indian
tiled within 72 hours after death with the Maryland Wygiene.	item 2.1 is marked offise than instition, or rems 25s or 26s-1 should be routilised at other traumatic event, the Medical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed 1 XYes	Forces? s 2 ☐ No		it Yes, sp	ecify Cubar	Specify:	uerto Ri	can, etc.)		Black, W	hite, et	tc.
hou	E E	edt	15. Decedent		Dates. 30-		dent's Us	sual Occupa	tion			16b K	(ind of Busine	ss/Indi	ıstrv
in 72	Aedic	Completed	(Specify only highes	grade complete		(Give	kind of v	vork done di use retired)	urina most of	working	1	100.11	and of Basino	3011100	
3 with	THE STREET	E	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	engi	inee	r				boi	iler pi	Lant	
H H	vent.	Bec	17. Father's Name (First, Middle, L	,					18. Mother's	Name (First, Middle	e, Maider	Surname)		
uld b	tice	2	Edgar Frederic	k Donald	lson				Rache1	L Cla	audia	Coop	per		
and t	E L		19a. Informant's Name/Relationsh										or Town, Stat	e, Zip C	Code)
and and	n 27		Anne B. Donald	son/spou					Highw			lis,	MD 2	140	1
permit. Peges 1 and 2 should be filed within Department of Hearth and Mental Hygiene.	ny or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp.			Place of Dispo cemetery, crer	natory o	lame of r other place)	Dat	le	20c. L	ocation - City	or Tow	m, State
permit. Departn	any inju		21. Signature of Funeral Service	icensee Warde,	Divecto	r Š	Name tate alti	Anato More,	of Facility Omy Boa MD 2	ard 1201	655 W	. Ba	1timor	e S	treet
9	P		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications in	caused the dea		· · · · · · · · · · · · · · · · · · ·				respiratory	arrest,			Approximate Interval Between
Phys /Me	ician dical		Immediate Cause (Final disease or condition resulting in death)	_ a	Chron co (or as a conse	quence of):	bot	ruti	re Fo	21ms	on and	5	Seen	. .	Onset and Death
Exan	niner	er	Sequentially list conditions, if any, leading to immediate	b	o (or as a conse										
scuted	transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С											
cete be executed	pnysicien and s the burial-transit	al Ex	resulting in death) Last	Due t	o (or as a conse	quence of):									
	pnys	edical		a											
OI VII DO	been signed by the attending p should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregn birth 2 Fet gnant at time of	al death 3	Ectopic Other	pregnancy specify)					23d. Date of Month		y Day Year
hatth	de by		Part II. Other significant conditio	ns contributing to	death but not re-	sulting in the u	nderlyin	Cause dive	n in Part I		23a Did	tobacco	use contribut	e to the	cause of death?
w requires 1	od bi	d by	onpha	19-12		HCR		, oddoo giro	.,,,,		1	-			biy 4 □Unknown
2 8	shou	Completed		1 3						_	24a. Wa	s an	24b Were	auton	sy findings available
n e	s certificate has b lirector, page 2 sl	шс									auto per	opsy formed?	prior	to com	pletion of cause of
icien: T	or, p	ပိ	25. Was case referred to medical						26. Place of	Dooth /	1 Yes		1 1 1	/es 2	≧∐ No
/sicie	s cerr direct	0 0	examiner? 1 ☐ Yes 2 2 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 🗆 I	Othe	-				6 Other (5	Snacify!	
i f	er thi	n: T	27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time o		28c. Injury Work			_		ry occurred	(Pacity)	
Attending r death.	e fun	atlo	1 Hatural 5 Pending	3	onin, Day 19ai)	Injury	М		r 'es 2□No						
DIVIS alor Atte	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 288. Pla	ce of Injury - At I Iding, etc. (Spec	nome, farm, str	reet, fact	ory, office		28		(Street al		Rural	Route Number,
To the Hospitel or Attending Phys within 24 hours after death.	To the Funerel Director; After this certificate it completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Medical I	g Physician: To t Examiner: On the and m	the best of my kn basis of examin anner stated.	owledge, deat ation and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and p inion, death o	occurred	d due to the l at the time	e cause(s o, date an	and manne d place, and	r as sta due to t	ted. the cause(s)
To th	comp	Me	29b. Signature and title of certifier					9c. License					ate signed (M	onth, D	ay, Year)
	-		Ma a u	rele	- m5			0	3/7	78		MA	4 3	-	2005
			30. Name and address of person	who completed ca	tuse of death (Ite	m 23a) (Type,	Print)	7.203	3 /	1	100	ruce	1	1	
			30. Name and address of person of the second	MILL	ANI	10		AWN	Des C	()	MO	21	43,		
ě	Sta Registr		31. Date filed (Month, Day, Year)	32	. Registrar's Sign	ature	6 11	77							

			Please I	ype or Print in				•		.egible.	
			1 _ State	State of Maryla	•	ment of H <i>licate of L</i>		ental Hy	•	0001	11448
			Registrar 1. Decedent's Name (First, Middle, Last)		Cerui	icale of L	Jeaui	2. Date of De	Reg. No.	ZUU.	3. Time of Death
	Physici /Medic		MARCARET F	ARVER	1			Month	O S	300t	5910 PM
	Examin	er	4a. Facility Name (If not institution, give	Street and number)	Home 4		Location of Death		46.0	County of Dee	
			5. Social Security Number 6. Sex	JAL PIKE	- 1	Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	ARI	thplace (State or Foreig
ķ.	Funeral Director			M 2₫F 82		onths Days	Hours Min.	(Month, D	ay, Year)	C	ountry) yland
	p.		Usual Residence of Decedent		-				, 1,2		
	anylar ethow	5	10a. State 10b. County		City, Town or Locati	on					10d. Inside City Limit
	he M	Directo	Maryland Carroll 10e. Street and Number	Sy	kesville	101 7:- Codo			40 - 000		
	with t					10f. Zip Code				en of What Co	•
	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f ehow to Miccical Exemirer must be notified at	Funerai	1119 Streaker Rd.	12. Was Decedent Ever in	n U.S. 13. Was	21784 Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or N		ed Sta	
9	after o	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Rican, etc.)		Black, Whi	
ğ	ours a	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2X No	Specify:			Specity: Wh	iite
5	72 h natu	Completed	15. Decedent's Edu- (Specify only highest grade	cation a <i>completed)</i>	(Give kin	t's Usual Occupa d of work done o	luring most of workir	ng .	16b. Kin	d of Business	/Industry
12	within ane.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired)		Cnui	nafia1	1 0+-+ 11
2	Hygie ther ther		17. Father's Name (First, Middle, Last)		Nurse		18. Mother's Name	(First, Middle			d State Ho
aryland 21215-0036	id be ental ked o	To Be	Ed Atikson				Minnie B1			,	
ary	shou and M mar umat	-	19a, Informant's Name/Relationship (Ty	рө, Print)	19b. Mailing A	Address (Street a	and Number or Rura	Route Numb	er, City or	Town, State,	Zip Code)
Z,	and 2 valith a 127 l		Barbara Owens (dau	ghter)	1119 St	reaker	Rd. Sykes	ville,	MD 2	1784	
ore	of He		20a. Method of Disposition 1 ➡ Burial 2 □ Cremation 3 □ R	emoval from State	 Place of Disposition cemetery, cremate 	on (Name of ory or other place	e) D	ate		ation - City or	Town, State
Ĕ	Pag ment ant: I ury o		`4 □ Donation 5 □ Other (Specify)	M M	organ Cha	pel Ceme	etery 05/	0/2005	Woo	odbine,	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show any injury or other traumatic event, It a Miccical Exportment must be notified at once.		21. Signature of Funeral Service/License	ellas	Burn	ame and Addres rier-Que West O	s of Facility en Funera ld Libert	1 Home	and Winfi	Cremat	ory, P.A.
	2		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the d						H eller	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARDIO	· Pul Mon	ARY	ARREST				Onset and Death
	/Medical Examiner		resulting in death)		requence of):		7.				1
	Examiner	_	Sequentially list conditions,).	TENSIEN						teay
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con:	sequence of):						
	le be executed ysician and e burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a con:	sequence of):						
760,	siciar buri	a	L.	4							
	g phy as the	edic									
Box 68	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the l	Physician/Medic	230. Has decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		topic pregnancy			23	3d. Date of de	livery
	ne deal the att hed for	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant at time		ther (specify)				Month	Day Year
P. 0	that the de ed by the detached	Phy	9 Unknown								
	res tha signed be det	by	Part II. Other significant conditions con		resulting in the unde	rlying cause give	on in Part I.		Yes 2 2	^	o the cause of death?
0.00	w require been signations bear signature	eted	osteo antiri								
Vital Records,	has b	Completed	92169 00011	1/2				24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
a	ysician: The is certificate hadrector, page		OF Was are stand to section					1 ☐ Yes	2 MNo	1 ☐ Yes	s 257 No
	sicia certi	o Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpatient	Othe	26. Place of Death				
o	ding Phys th. After this funeral di	-	27. Manger of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 Nursing Hon	8d. Describe			ecity)
<u>0</u>	nding ath. r: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		res 2 □ No				
Division	or Attanding ifter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, street,	factory, office	2		(Street and	Number or R	ural Route Number,
Ö	ital or rs aft rai Dii	Cer		oundary, other (op				ony or re	,,, olalo,		
	To the Hospital or Attank within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death or nination and/or inves	curred at the tim tigation, in my op	e, date and place, a pinion, death occurre	nd due to the od at the time	cause(s) a , date and p	ind manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	00. C		29c. License			29d. Date	signed (Mon	th, Day, Year)
	On the		11 19 40		And the second s	D-	20407		May	61	2005
	6		30. Name and address of person who or N B WELLANKI, 8	mpleted cause of death ((Item 23a) (Type, Prin	Berkina	7, #306,	Colu	rein.	MO.	21045
	Sta		31. Date filed (Month, Day, Year)	32. jegistrar's Si	ignature	160	•				
	Regist		MAY 0 9 20	US Breve	14 19						
DH	HMH 17 Rev 1/2	001			•						

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Box 68760,	
P.O.	
Records,	
Vital	
of	
Division	

			_ For	State of M		nd / Depa	artment of H	łealth a	and Mental H		•	107500
			1 - State Registrar			Ce	rtificate of	Death		Reg. No	6000	15509
	Physici /Medic		1. Decedent's Name (First, Middle, Eliza	Fulwood					2. Date of Month	Death Day 2	Year 200	3. Time of Death 5 9:53 AM
	Examin		4a. Facility Name (If not institution, SINA) HOSP	and a	SAL	TIMORO	4b. City, Town, or	Location of		4c.	County of Dea	th
	Funeral Director			6. Sex 7. Ag 1 M 2 F	6 (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. 8. Date of the Min. (Month). April	Birth Day, Year)	Co	thplace (State or Foreign puntry) eorgia
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Ba-f s	cto	Md.		Bal	timor	re					1 X Yes 2 No
	h with th 23a or 21 st be no	ai Dire	10e. Street and Number 2906 Sulgrav	e Avenue			10f. Zip Code	1205			izen of What Co USA	ountry?
920	be filed within 72 hours after death with the Maryland Ital Hygiene. I have matural, or Items 23a or 28a-f show other than "natural, or Items 23a or 28a-f show event, I're Medical Examinet must be multiled at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 2 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origan, Mexican Specify:	gin? (Specify Yes or i, Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	e, etc.
Ŏ.	2 ho	ted	15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation		16b. Ki	ind of Business	/Industry
Baltimore, Maryland 21215-0036	2 should be filed within 7 and Mental Hygiene. Is markad other than "n aumatic event, Ire Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or s	5+)		kind of work done of DO NOT use retired CV1SOr	du <i>ring</i> most 1)	t of working	1	ryland te Gov	
ğ	be filed htal Hygie nd other event, III	Be C	17. Father's Name (First, Middle, L	ast)				18. Mothe	r's Name (First, Midd	lle, Maiden	Sumame)	
an	should be and Mental s markad o umatic eve	To B	Joseph Pool	e Sr.				Ros	a Lee La	wren	ce Poo	le
ary	shound N	_	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Numbe	er or Rural Route Nun	nber, City o	r Town, State, 2	Zip Code)
e, K	l and lealth im 27 her tr		Joseph Poole 20a. Method of Disposition	Jr. (Brothe					, Baltim	-		
imor	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marks any injury or other traumatic once.		1 1 Surial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp				osition (Name of matory or other place norial P			*	ocation - City or dlawn ,	Maryland
3alt	Departi Departi Importi any Inj		21. Signature of Funeral Service L	icensee					y Tri-Sta	te F	/S/Inc	Alona
	402 8 Q		goons 1-	ener					NW.,Wash		C. 200	
	Physician		shock, or heart failure. List of Immediate Cause (Final	complications that caused inly one cause on each li	the deat		ar the mode of dyin		cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a conseq	-	MINCEL					6 MONTHS
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):						
	ecuted and -translt	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c								
760,	ate be executed tysician and he burial-transit	cai	Tooghing III dodainy 2200	Due to (or as	a conseq	uence or):						
89 x	leath certificate attending phy	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancy						
.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3[Ectopic pregnancy Other (specify)				23d. Date of deli Month	Day Year
4	that the dead by the detached	/ Ph	Part II. Other significant condition	18 contributing to death b	ut not res	ulting in the u	nderlying cause give	en in Part I.	23e. Dio	tobacco u	se contribute to	the cause of death?
Records,	w requires that been signed should be dei	ted by								Yes 2	□No 3□Pro	obably 4 Unknown
Reco	he law r has be ge 2 sh	Completed							24a. We	is an lopsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
	ician: The I certificate ha rector, page		OS Man and a madical						1 ☐ Yes	a No	1 ☐ Yes	20 No
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		5D/0-1	t 3 DOA Othe	OF.	of Death (Check onl)			
ō	Phys er this eral di	To To	27. Manner of Death	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time of	IL SU DOA	4 1401	rsing Home 5 Re			cify)
ion	nding th. r: Afte e fun	atio	1 Natural 5 Pending 2 Accident investiga		y Year)	Injury		k? Yes 2□N	No			
Division of	l or Atter after des Diractor	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At ho	ome, larm, str	eet, factory, office	-	28f. Location City or T	(Street and	d Number or Ru)	ral Route Number,
W	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Ce	29a. Certifier 1 Certifying (Check only one) 1 Medical S	Physician: To the best xaminer: On the basis of and manner sta	examina	wledge, deati	n occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, and due to the control of t	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	ro th vithin ro th	Me	29b. Signature and title of certifier				29c. License	a number		29d. Date	e signed (Month	n, Day, Year)
			> omor	Pm - Bou	jan	}	RES	; - 1	000	MA	Y 2	2005
_			30. Name and addless of person w	no completed cause of g				HOSP	ITAL OF	Br	ALTIN	WRE
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	_	ture				-		
DHI	MH 17 Rev 1/20		MAY 0 9 2	2005	1	*	1					
						ORIGINA	L					

an	Decedent's Name (First, Min	ddle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death
an cal	Jean		Payn	ie			Frat	ino_		April	28	2005	8:45 p ^M
ier	4a. Facility Name (If not institu		nd number))		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Deat	h
	321 Hemsley 5. Social Security Number	Drive 6. Sex	7.4	no (la uro	ast birthday		enst	OWN If Under	24 Hrs	O Date of Bird		en Ann	
	218-38-6506	1 □ M 2X		66 (iii yis. i	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 20	y, Year)		hplace (State or Foreign
	Usual Residence of Decedent									reb. Zu	193	y was	shington, DC
L	10a. State 10b. Cour	nty		10c. City	, Town or L	ocation							10d. Inside City Limits
Director	MD Quee	n Annes		Qu	eenst	own							1 ☐ Yes 2x TxNo
Dire	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What Co	ountry?
	321 Hemsley		Deserted	Constall.	C 40	W D		658	-:-0.40		US		1-4
Funeral	11. Marital Status 1 □ Never Married 2 ☑ N	Arm	Decedent ed Forces	?	5. 13.	If Yes, spec	ify Cuba	n, Mexicar	gin ((Spe 1, Puerto	ecify Yes or No- Rican, etc.)	14	Black, White	
þ	3 ☐ Widowed 4 ☐ Divord	ed If Ye	Yes XX es, Give r or Dates:			1 🗆 Yes	2 ∑ No	Specify:			S	pecify:	White
Completed	15. Deced	dent's Education	lotod)		16a. Dece	dent's Usua	I Occupa	ation	t of worki	5.5	16b. Kind	of Business/	Industry
nple	Elementary/Secondary (0-12	thest grade complete: 2) Coll	ege (1-4or	5+)	life.	DO NOT us	e retired))	t or worki	ng			
Con			4		Admi	nistra	itive						College
Be	17. Father's Name (First, Midd									(First, Middle,	Maiden Si	umame)	
2	Thomas Charl 19a. Informant's Name/Relation		14)		105 14.	ing Add	/Ct-=-		len :		0.4	Taum Ott	Zin Co do l
	Jim Fratino		•							l Route Numbe			
	20a. Method of Disposition	(Husballu	,	20b. P	lace of Disp	osition (Nan	ne of			eenstow		tion - City or	
	1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		from State	,	metery, cre	•		·	E /0 /	2005			
	21. Signature of Funeral Servi			п1	11cre	St Cen 2. Name an			5/2/:	2005	Anna	polis,	MD
	1 - 3ri A.	C	_			Hard	lesty	y Fun	eral	Home,	P.A.	100 0	1101
	23a. Part 1. Enter the disease	or complications	that cause	d the death	. Do not er					e Anna		, MD 2	Approximate
	shock, or heart failure. I Immediate Cause (Final	•				,	4						Interval Between Onset and Death
	disease or condition resulting in death)	a D	Neta ue to (or as	a consequ	ence of):	Meni	221	ong					
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ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ue to (or as	a consequ	ience of):								
Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	С											
Ex	resulting in death) Last	D	ue to (or as	a consequ	ience of):								
dlcal		d											
Physician/Me	IF FEMALE:	23c If ve	s, outcome	of pregna	nev								
clan	23b. Was decedent pregnant in the past 12 months?	10	Live birth Pregnant a	2 Fetal	death 3	☐Ectopic pr					230	d. Date of deli Month	very Day Year
yslo	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		Unknown	it time or de	satti 3	_ Other (sp	ecity)		-				
y Ph	Part II. Other significant cond	litions contributin	g to death b	out not resu	ılting in the I	underlying ca	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
d by										1 🗆 Y	es 25	No 3□Pro	obably 4 []Unknown
Completed										24a. Was	an :	24b. Were au	topsy findings available
dwc		· · · · · · · · · · · · · · · · · · ·								autop perfor	med?	prior to death?	completion of cause of
a)	25. Was case referred to med	ical						26 Place	of Death	1 Yes	2 No	1 🗆 Yes	2 25. No
To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	1 🔲 Inpati	ent 250	ER/Outpatie	nt 3 D0	A Othe			ne 5 X esid		Other (Spec	n(v)
	27. Manner of Death		Date of Inju	JIV I	28b. Time o		8c. Injury Work			28d. Describe h			,,
atlo	Z [] / tooldont	stigation	(INOTITE, DO	ay rous,	injury	М		res 2□I	No				
Certification:		ald not be ermined 28e.	Place of In	jury - At ho	me, farm, si	reet, factory	, office		2	28f. Location (S City or Tow		Number or Ru	ral Route Number,
Cer									į.				
edical	(Check only 2 Medic	lying Physician: cal Examiner: On	To the best	of my know	wledge, dea ion and/or in	th occurred a	at the tim	e, date an	d place, a	and due to the o	ause(s) ar	nd manner as	stated. to the cause(s)
Med	one)	and	manner st	ated.									
-	29b. Signature and title of cert	T)			0 (number	. (>	2		signed (Month	
Į	100	X. Ten	e m	O	Professi	B	L15	095	12		7-2	9-05	
	1000	41-0											
	30. Name and address of pers	on who completed	cause of c	death (Item	23a) (Type	Print)		4 0	/	2 17		0-	1 > 67
ato.		on who completed	d cause of d	death (Item	Hark	Print)	1 050	itul	1 6	Baltim	\$ (\$	MD	21257
ate rar	John La	on who completed tests of the completed tests	32. Registr	death (Item	Hack	Print)	1 050	Tul	1 6	Baltim	٥٥٩	MD	21257

Physician Curtis L. Gregory May 2, 20 20 20 20 20 20 20 2			State Unpend Ite			- Cei	rificate of	Death			2005	3. Time of Death
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Tour State Tour State Tour To		5							lin. (Month, E	Day, Year)	9. Birth Cou	intry)
Second 2 Gramation 3 Family Plot 5-14-05 Boydton, Va.	*	-		у	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Lin
Section Chronic Cocaine Use Family Plot Family Plot South	f sho	<u>i</u>	Md. Bal	timore		To	wson					X □Yes 2□
Family Plot Family Plot Souther (Specify) Family Plot	3e or 28a 1 be noti	1		own Court	: Apt.	314		04				intry?
Second 2 Gremation 3 Removal from State Family Plot 5-14-05 Boydton, Va.	or liems 2.	1	1 Never Married 2 ☐ Ma	Armed 1 Ye If Yes,	Forces? s 2 No Give X		f Yes, specify Cut	an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	lo-	Black, White	, etc.
Securitary Service of Fundance Continuous Service Serv	ed b	-	15. Decede	int's Education		16a. Dece	dent's Usual Occu	pation		16b. Ki		
Section Part Plot	e Medi	-	Elementary/Secondary (0-12)	T		life.	DO NOT use retire	ed)	working			
Table Company Compan	ant, in			e, Last)		Dei	.r-miproy		Name (First, Middi			rigerier
Table Company Compan	To B	:	Willie		(Gregory	7	Liz	zie		Harr	ris
Section Sect	Iraum					1						_ '
Section Sect	other	2		у ы		_				_		
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on seath line. Intracerebral Hemorrhage	יייץ פר								-14-05	Boy	dton, Va	ì.
shock, or heart failure. List only one cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Immodiate Cause (Final Insenting in death) Immodiate Cause (Final Insenting in death) Sequentially list conditions, and the immodiate cause on each line. Immodiate Cause (Final Insenting in death) Immodiate Cause (Final Insenting in death During in death Duri	any inju	1	21. Signature of Funeral Service	e Licensee	ane-				Ba 1101	altim E. N	ore, Md.	
Sequentially list conditions are yielded to immediate cause. Enter Underlying a stay, learning to immediate cause. Enter Underlying cause (Disease or Injury that initiated events in the past 12 months? Due to (or as a consequence of):	edical		shock, or heart failure. Lis Immediate Cause (Final disease or condition	st only one cause o	n each line. racerebra	al Hemo		ing, such as care	and of respiratory	arrest,		Interval Betweer Onset and Deat
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	je je		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due	to (ui as a cuiism	qualica oi).	rosclerot	ic Card	iovascula	ar Di	sease	
Chronic Cocaine Use 1	use as	1	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Liv 4 □ Pr	e birth 2 □ Feta egnant at time of c	al death 3		ey .				
autopsy performed? Continued by the performed by the performed? 1	b e d	ר ב			o death but not res	sulting in the u	nderlying cause g	ven in Part I.			N =	
25. Was case referred to medical examiner? 1	n ye 2	-							aut	opsy formed?	prior to co death?	mpletion of cause
1 L Yes 2 No	ctor, p) 2		al				26. Place of I	1		1 72 33	22.10
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	meral dii	1	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Da		28b. Time o	f 28c. Inju	ry at ork?				fy) At Scen
29a. Certifier 29a. C			3 ☐ Suicide 6 ☐ Could	min ad 200. Fit	ace of Injury - At h ilding, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location City or To	(Street and own, State	d Number or Rur)	al Route Number,
29b. Signature and title of perifier 29c. License number OCME 29d. Date signed (Month, Day, Year) May 6, 2005	od in by th	5	29a. Certifier 1 Certify	al Examiner: On the	e basis of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and pl opinion, death o	ace, and due to the	e cause(s) e, date and	and manner as s place, and due t	stated. o the cause(s)
May 6, 2005	a runaral Diractoristelly filled in by the		(Check only 2 Medics one)	anuij			20-11-			29d Dat	a signed (Month	
	completely filled in by th		one)		//					25G. Dat	o signed (Month),	Day, Year)

		-	_ FOI	artment of Health and Mental Hy	giene Reg. No. 2005 15512
	Dhuaiai		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
	Physicia /Medic	al .	William Roger Grace	5	4 2005 1:35 P M
}	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			CHESAPEAKE HOSPICE HOUSE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Linthicum If Under 1 Year If Under 24 Hrs. 8. Date of Bir	Anne Arunde1
	Funeral Director		213-30-8948 1 M 2 F 73 Yrs.	Months Days Hours Min. (Month, Da Jan 29	th 9. Birthplace (State or Foreign Country) 1932 MD
			Usual Residence of Decedent		,
	how	_	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Be-f s	cto		Burnie	1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Number 7025 Cresthaven Drive	10f. Zip Code	10g. Citizen of What Country?
	s 23e	- a		21061	U.S.A.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menth Hygiene. Item 27 Is marked other then "naturel; or Items 23e or 28e-f show other treumatic event, the Medical Examinations to notified at	by Funeral	1 Never Married 2. Married 1 X Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	Black, White Specify: white
Maryland 21215-0036	2 hou ature		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
215	within 7 ene. then "n	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
7	filed wil Hygien Sther th	Con	12 Ware	ehouse Man	Farming Equipment
pu	be filed Ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	·
<u> </u>	should be find Mental He marked of	ပို	William Leroy Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Anna Mae Bra	
Ma	d 2 sho th and t7 le my treum			Cresthaven Drive, Glen B	
	1 and 2 Health tem 27		20a Method of Disposition 20b. Place of Dispo	osition (Name of Date	20c. Location - City or Town, State
ē	Pages nent of ant: If it		1 Burial 2 Noremation 3 Hemoval from State	matory or other place) ke Cremation May 5,2005	Stevensville MD
Baltimore,	- 문변증	1		2. Name and Address of Facility Singleton	
m	permi Depa Impo any Ir pnce		1// 1 1/1 1/2 10 10 10 10	Second Avenue S.W., Glen	
	. 8.		23a Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cancer	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):		To Votos
	Examiner		Sequentially list conditions, b		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
•	be executed sician and burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760,	siciar siciar buria		d		
9	ifficate g phys as the	edic			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
rds	w require: been sig should b	ed b		1 🗆	Yes 2□No 3□Probably 4XUnknown
Records,	The law re cate has bee page 2 sho	Completed		24a. Was autoj perfc 1 U Yes	
Vital	yelcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of V	Phyelcien: this certificated director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		dence 6X Other (Specify) Hospice
n o		on:	27. Manner of Death 1 ↑ Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Work?	how injury Pocurred
Sic	death. ctor; A y the fu	lcat	2 Accident investigation 3 Suicide 6 Could not be determined elemined.	M 1 Yes 2 No	Street and Number or Rural Route Number,
Division	lor A after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or To	wn, State)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atte completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea continuous and manner stated.	exectination in my oninion, death occurred at the time.	date and place, and due to the cause(s)
	To the within comp	Σ	29b. Signature and title of certifier	29c. License number D39505 Print) Hospital Tw. Glan	29d. Date signed (Month, Day, Year)
	6	1	30. Name and address of person who completed cause of death (Item 23a) (Type Yudhish narkon 30.5	Hospital m. Glan	Sum'e ND 21061
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	W	

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Ce	rtificate of	Death	,	Reg. No.	
			1. Decedent's Name (First, Middle, L	ast)				2. Date of De		3. Time of Death
	Physici /Medic	_	Ka	thleen Joan Gl	aser				, 2005	12:50 P
	Examir		4a. Facility Neme (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Deat	h
			Gilchrist Center			Towson	_ KII		Baltimo	
	uneral irector		190-24-9673	Sex 7. Age (In yrs	. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		$\stackrel{\text{th}}{\text{I'}} \stackrel{\text{y-ea}r}{\text{1}} 1929 \stackrel{\text{g. Birt}}{\text{Po}}$	hplace (State or Foreig untry) ennsylvania
pur	*		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
faryla	sho	5	Maryland Balti		Luther					1 ☐ Yes 2√2 No
the A	28a-	Director	10e. Street and Number	more	Lucher	10f. Zip Code			10g. Citizen of What Co	
ath with	23a or	ralDir	1318 Burleigh Ro	ad			.093		United Stat	tes
1275-0036 within 72 hours after deeth with the Maryland	Department of Health and Menhar Hyglane. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinat must be indiffied at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Tyes 2 XNo If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	"natur	Completed	15. Decedent's (Specify only highest of	Education rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business/	Industry
with N	than 60	μ̈́	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Teacher	-,		Education	on
D = 0	other ant,		17. Father's Name (First, Middle, La	<u>.</u>			18. Mother's Na	me (First, Middle	, Maiden Surname)	
ed be	ked c	To Be	John Fr	ederick Lehria	ın		Mary K	athleen	Aunks	
shou	in mark	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Ri	ural Route Numb	er, City or Town, State, 2	Zip Code)
Ind 2	alth a		Mr. Charles Glas	er (husband)	1318	Burlei h	Road, Lu	thervil	le, Maryland	1 21093
<u>ရှိ</u>	item		20a. Method of Disposition	1	Place of Disp	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State
Page 3	int: If		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 【 Other (Spec		•		1	0. 2005	Timonium.	Marvland
baltimore,	Imports any inju		21. Signature of Funeral Service Lic		T. Ch	2 Name and Addre ISholm Fi	ineral Se	rvices	of Dulaney V	Valley, P.A
-		\Box	23a Part1. Enter the disease, or co	mplications that caused the dea						Approximate
Die	ysician		shock, or heart failure. List on Immediate Cause (Final		Cance	13 -1000				Interval Between Onset and Death
	nedical		disease or condition resulting in death)	aDue to (or as a conse	auence of):	u-rec	wrent			monters
Ex	aminer			200 to (0) 40 4 041100	quonos ory.					
	K	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):				- ()	
X 68760, certificate be executed	ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
O,	an an rial-tr		resulting in death) Last	Due to (or as a conse	quence of):					
68760, ificate be ex	nysici ne bu	cal		d						
	ng ph as th	Medical	IF FEMALE:							
egath and	ed by the attending physician and detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 1% nonths? 1 □ Yes 2√0 No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	taldeath 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
ag 🗗	ed by deta		Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use contribute to	the cause of death?
	been signed t should be det	d by						10	Yes 2□No 3□Pr	obably 4 Dunknow
Vital Records, P.O sician: The law requires that the	S C/I	Completed						24a. Was		utopsy findings available completion of cause of
a He	certificate ha rector, page							1 Yes	20 No 1 Yes	2 🗆 No
of Vita Physician:	is certific director,	Be	25. Was case referred to medical examiner?	Hospital:	7.50	O#	ner	ath (Check only	1)	1.1
o a	두 ㅠ	. To	1 Yes 2 No 27. Manner of ath	1 ☐ Inpatient 2 [28a. Date of Injury	ER/Outpatie	nt 3LI DOA	4 Nursing i		dence 6 Other (Spechow injury accurred	city) Notflex
DIVISION i or Attending	After funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No			
VISION	offer death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Injury - At	home, farm, si				Street and Number or Ru	ural Route Number,
בַּ בַ	Olred in b	Certification;	4 Homicide	building, etc. (Spec	cify)			City or To	wп, State)	
Hospits	within 24 hours effer death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Ex	Physician. To the best of my kraminer: On the basis of examin	iowiedge, dea nation and/or i	in occurred at the ti rvestigation, in my	me, date and place opinion, death occi	e, and oue to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
o the	thin i	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (Monti	h, Day, Year)
ĭ	3 ⊬ 8		MILN	Uno.		De	2303		MAN	7
-	1		20 Name of the contract of the	o completed assess of death (the	nm (22+) (T	Drint\			1000	
8	,		30. Name and a ress of person when the same of the sam			Charle	S 6+ B	salting	ore no Ziz	roy
	St Regist	ate rar	31. Date filed (Month, Day, Year)	Registrar's Sign	natere	848)				1

G-laser, KATHLEEN May 6, 2005 125mm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** May 4 2005 АМ 8:24 Mary Sue Harrison /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | July 5, 19. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 1933 71 Maryland 220-28-7994 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County if item 27 is marked other then "natural", or items 23e or 28e-f show or other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Funeral Directo Maryland Carroll Woodbine 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21797 1950 Heron Dr. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itsm 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Her Home 12th Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Janie Mercer Alpha Raymond Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 659 Mt. Airy, MD 21771 Holly Frey (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. St. Michael's Cem. 5/9/2005 Poplar Springs, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCUD **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No this certificete 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred after death. Diractor: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henderson J. MD 2a 13 manchester RD, Manunester MD 21102 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State MAY 0 9 2005 Registrar

DHMH 17 Rev 1/2001

		For State Registrar	State of N	Maryland /	-	rtment of H tificate of L		Mental H	ygiene Reg. No.	005	155	15
Physic	cian	1. Decedent's Name (First, Midda William L.						2. Date of D Month	Death Day	2005	3. Time of 6:10	Death P M
/Med Exam		4a. Facility Name (If not institution Copper Ridge	Hedges on, give street and number	er)		4b. City, Town, or Sykesvil		May	4c. C	2005 County of Death		
Funera Directo		5. Social Security Number 035–22–2744	6. Sex 7. 1 M 2 F	Age (In yrs. last 82	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. 8. Date of E (Month, I Februar	N. at		place (State or intry) Chusetts	r Foreign
nyland thow		Usual Residence of Decedent 10a. State 10b. Count		10c. City, To							10d. Inside Cit	ty Limits
r 28e-f	Director	MD n/s	ā ————————————————————————————————————	Ва	ltimor	10f. Zip Code			10g. Citiz	en of What Cou	1 XYes	2 NO
th with	ral D	200 Cross Keys	Road #40			21210			U.S	.A.		
urs after dea al', or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 🏿 Widowed 4 □ Divorce	If Yes, Give	s? ∃No WW TT		Vas Decedent of Hi Yes, specify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Perto Rican, etc.)	1	4. Race - Amer Black, White Specify: W		
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene filem 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic svant, the Medical Estation of matter collibed at	Completed		nt's Education est grade completed) College (1-40		(Give I	lent's Usual Occupa kind of work done do DO NOT use retired, e Professor	luring most of v)	working		d of Business/li ation	ndustry	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than eny injury or other traumatic svant, Itam Itam Itam.	To Be Co	17. Father's Name (First, Middle James B.		1				lame (First, Midd		iumame)		
d 2 shouth and N		19a. Informant's Name/Relation James Hedges- so				g Address (Street a					. ,	
Pages 1 and nent of Health int: If Itam 27 iry or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 □Removal from Sta	20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other place vice Corpor	9)	Date	20c. Loc	ation - City or T		
permit. P Departme Importan eny injur	SUCB.	21. Signature of Funeral Service		m G. Dau	22	. Name and Addres	s of Facility		105	O York son, Mi		
Physiciar		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complications that cause to only one cause on each	sed the death. D	Do not ente		g, such as card				Approximate the first and D	ween
/Medica Examine	r .	resulting in death) Sequentially list conditions.	b	as a consequen								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	as a consequent								
tificate ng phys	edical		0.									1.5
ires that the death certific signed by the attending pd be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 2 ☐ Fetal death t at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)			23	d. Date of delin Month	-	'ear
quires that I n signed by uld be deta	by	Part II. Other significant condit	ions contributing to death	h but not resultin	g in the un	nderlying cause give	on in Part I.		tobacco us	e contribute to		
ysician: The law requir is certificate has been si director, page 2 should	Completed							per	is an opsy formed?	24b. Were autoprior to condeath?	ompletion of ca	wailable luse of
Physician: The this certificate al director, pag	Be	25. Was case referred to medic examiner?	Hospital:			Othe	r /	eath (Check only				
5 ਵਿੱਚ ਜ਼	tlon: To	1 Yes 2 No 27. Mannal of Death 1 Natural 5 Pend	1 ∐ Inpo		Outpatient b. Time of Injury	28c. Injury Work	4 W Nursing	Home 5 Re 28d. Describe			fy)	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	ertification:	3 Suicide 6 □ Could	not be 28e. Place of	Injury - At home etc. (Specify)	, farm, stre	eet, factory, office			(Street and own, State)	Number or Rur	al Route Numb	7e <i>r</i> ,
To tha Hospital or within 24 hours affe To tha Funaral Dir completely filled in	edical C	29a. Certifier 1 V Certify (Check only 2 Medical	ing Physician: To the be if Examiner: On the basis and manner	s of examination	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and pla pinion, death oc	ace, and due to the courred at the time	e cause(s) a e, date and p	nd manner as s lace, and due t	stated. to the cause(s)	
To the within To the comp	Me	29b. Signature and title of certifi	form M	sel me	>	29c. License	number 55974	3	29d. Date	signed (Month,	Day, Year)	
5+17		30. Name and address of perco	who completed cause of		la) (Type, I	Print)	2 307	westr	ninste	Y MK	> 21/5	57.
S Regis	State strar	31. Date filed (Month, Day, Yea.		istrar's Signature	A	arte						

State of Maryland / Department of Health and Mental Hygiene For Stata Registrammend item #1 PER ME G843 5/19/05/care of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May OÎ, 2005 **Physician** 23:24 Hawkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cheverly Prince George's Hospital Center Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | January 9, 84 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 21 Maryland Director 213-08-3927 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow the Medical Examiner must be notified at 1X Yes 2 □ No Directo Upper Marlboro Maryland Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20772 , or Items 23a U.S.A 11404 Rhodenda Ave Pages 1 and 2 should ba filed within 72 hours after death ment of Health and Mental Hygiene. and it if the 27 is marked other than "natural", or Items 23, ury or other traunatic event, the Medical Examination and by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker 12 Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hurdle Jannette John C. Hawkins Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parents 11404 Rhodenda Ave. Upper Marlboro MD 20772 JohnJr.& Jannette Hawkins Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 5-6-05 Resurrection 4 □ Donation 5 □ Other (Specify) Clinton, MD 21. Signature of Foneral Service License 22. Name and Address of Facility Adams Funeral Home P.A aquasco MD 20608 191 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Injune Multiple /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, sign. 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2□No Z/Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home txXYes 2 □ No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 | Pending investigation 6 | Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office | 28f. Location Street and Number or Rural Route Number, City or Town, State) | Report of the basic of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 Suicide Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 02, 2005 Josha Treenberg MD OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L Giveen berg Tasha 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State MAY 0 9 2005 Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** DU17 6 LULU M. HART /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Avmas 1500 カッカイ If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Min. Davs Hours Months 1 □ M NY Director MAY 27, 1925 127.16.0906 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County ir than "natural", or Itame 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director ANNE ARUNDEL GLEN BURNIE MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number **APT 784** 21060 USA 7900 BENESCH CR. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
ant: If itsm 27 is marked other than "natural", or Ital iry or other traumatic event, the Medical Exam. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 📆 ivorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RESTUARANT unk WAITRESS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JENNY I. JOY THOMAS J. RYAN ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 1222 KENWOOD RD. GLEN BURNIE, MD21060 SHARON E. CUMBERLAND 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If its any Injury or otl once. 1 ☐ Burial Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 5.11.2005 BALTIMORE, MD of Funeral Service FINK FUNERAL HOME 426 CRAIN HWY SW 21. Sign GREGORY GLEN BURNIE MD 21061 M01148 23a. Parkt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequ nce of) Examiner Sequentially list conditions, if any, leading to immediate east. Early 1975 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Q 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an ertificate has funeral director, page 2 autopsy perform 1 Yes 2 No Hospital or Attending Physician: Be 26. Place of Death Check only one 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence Hospital: 6 ☐Other (Specify) 1 Nnpatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 \ Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig cause of death (Item 23a) (Type, Print) A WUSh-SUBITE 31. Date filed (Month, Day, 32. Degistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			_ State	State of Maryland		rtment of H			711115	15210
		97	Registrar 1. Decedent's Name (First, Middle, Last)			inoate or i		Date of Death	No.C UUJ	3. Time of Death
	Physicia		Roman Co	nehita J	uach	100		Month 5	Day o Syear	650PM
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)			Location of Death		4c. County of Death	. 1
			Continuum Car	2			resuille		Carro	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la 4. 20 F 76	ast birthday) _ Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Y	(ear) Cou	• *
	Director		112-22-4654 Usual Residence of Decedent	A 70			l l e	b 25 19	929 Ind:	Lana
	yland		10a. State 10b. County Carrol1		, Town or Loc Sville					10d. Inside City Limits
	e Mar	ctor								1 X Yes 2 No
	within 72 hours after death with the Maryland ane. Than "natural" or Items 23a or 28a-f show ta Nedleal Eserciner mast be notified at	al Director	10e. Street and Number 7420 Village Road	Apt 17		10f. Zip Code 21784		100	g. Citizen of What Cou USA	ntry?
	r deat	Funeral	11. Wantar States	. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Specifi an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ameri Black, White,	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2♥ No If Yes, Give Year or Dates:	1	Ù Yes ₩XNo	Specify:		SpecifyPhi1	lipino
21215-0036	2 hour	ted t	15. Decedent's Educa	ition	16a. Deced	ent's Usual Occup	pation	16	6b. Kind of Business/Ir	dustry
215	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retired	·	tant	clerical	
2	filed withi Hygiene. other than ent, the M	Соп		2	ac	IIIIIIISUFE	ative assis	Lant		
land	ould be fil Mental H tarked oth	To Be	17. Father's Name (First, Middle, Last) Juan Lazo				Rosalind			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene at the state of the than 27 la marked other than "natural", or liems 23a or 28a-1 show then traumatic event, the Medical Eventiner mant be notified at	_	19a. Informant's Name/Relationship (Type Rose Fabrick (daugh	e, Print) ter/executor)	19b. Mailin 7818	g Address (Street Northeas	and Number or Rural R st 150th St	oute Number, 6	City or Town, State, Zi ore, WA 98	028
Baltimore,	e = = 9		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	C4	emetery crem	sition (Name of natory or other plac cy Cremat	Date 5-10-0		ykesvi 11 e,	
Balti	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Licenses		22 P	Name and Addre	ess of Facility Haig 195 Sykesvi	ht Fune 11e, Md	ral Home & 21784	Chapel
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not ente	er the mode of dying	ng, such as cardiac or re	espiratory arres	st,	Approximate Interval Between
	r nysician		Immediate Cause (Final disease or condition	Lympi	homa				1	Onset and Death
12	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
	LXdiffiller	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	rted Insit	Examiner	cause. Enter Underlying Cause. Unsease or injury that initiated events c.	,						
á	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of);		-			
8760,	te be iysicia ne bur	dlcal	d.					<u></u>		
9	ing ph as th	Med	IF FEMALE:						100000	
.O. Box	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 O	 c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown 	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliver Month	ery Day Year
<u>α</u>		y Pr	Part II. Other significant conditions con-	ributing to death but not resu	ulting in the ur	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	E 00 E							1 🗆 Yes	3 □ Pro	bably 4 Unknown
Records,	e law has b	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Death (
of V	die S	To	1 1 1es 2 2 2010	ospital: 1 Inpatient 2	ER/Outpatien	I 3 DOA	Α		nce 6 Other (Spec	(fy)
o L			27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		d. Describe hov	v injury occurred	
Division	ten leat tor: the	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str]Yes 2 No	f, Location (Stre	eet and Number or Ru	ral Route Number,
Div	al or Attena after deat Diractor: d in by the	Certification:	4 Homicide determined	building, etc. (Specify	(y)	oot, ractory, smoo		City or Town,	State)	
	e Hospital or At 124 hours after o e Funeral Dirac letely filled in by	Medicai C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred at the ti vestigation, in my	ime, date and place, and opinion, death occurred	d due to the car at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/		29c. Licen			d. Date signed (Month	, Day, Year)
	_/		With li	h me)	000	58137		5/9/05	
,	49		30. Name and address of person who bo	npleted cause of death (Item 295 Sten	n 23a) (Туре, Р	Print)	58137 307 W	stmins	ter MO	21157
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registra Signa 9 2005	ature /	Goarle	<i>)</i>			

amend item/8, per Fil, 6843, 5/13/36k indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department	artment of Health and I rtificate of Death		ene 1 NG A A E TERRA
	•		Decedent's Name (First, Middle, Last)	initiate of Double	2. Date of Death	3. Time of Death
	Physicia	an			Month	Day Year
	/Medic		Ralph E. Johnson 4a. Facility Name (If not institution, give street and number)	4h Oit. Town and again (O at		1:00 P ^M
	Examin	er		4b. City, Town, or Location of Death	1	4c. County of Death
			11334 Browingsville Rd.	Ijamsville If Under 1 Year If Under 24 Hrs.		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 3	/9/1928. Birthplace (State or Foreign Country)
	Director		213-24-8486		March 19	3 1928 Maryland
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	aryla sho	ŗ.	Tod. Odly, Tolki of Ed	552(15)		1 ☐ Yes 2 ⊠ No
	8a-t	ctc	Maryland Frederick Ijamsville			1 163 2 2 100
	ih #	Directo	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	deeth with the Maryland me 23e or 28a-f show		11334 Browingsville Rd.	21754	Ur	nited States
	eme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
o	after or it		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	5 Triouri, 6(6.)	
213-0030	ours rei',	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Korean	TEL 198 250 NO Specily.		Specify: Black
ה ה	72 h	ompleted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ting 16	6b. Kind of Business/Industry
<u></u>	Par "	ple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Kii i g	
7	d wit	0	12th Forman	1	t.W	lliams Concrete
9	othe othe	e C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	aiden Sumame)
yland	ld be enta Ked	To B	Gabriel Orem	Alma .	Johnson	
>	mar mat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailli	ng Address (Street and Number or Ru		City or Town State Zin Code)
2	d2 s th ar treu treu		4400			
a)	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importment if time 27 is marked other then "natureli, or iteme 23e or 28a-f show eny injury or other treumatic event, the Movilsal Examinar must be notified at once.		Bethel I. Johnson (wife) 11334 20a. Method of Disposition 20b. Place of Dispo	Browingsville Ro	-	Oc. Location - City or Town, State
0	ges tofl		1 Burial 2 □ Cremation 3 □ Removal from State	matory or other place)	20	c. Location - City of Town, State
saitimore,	men ment: jury		`4 □Donation 5 □Other (Specify) Rest Have			ederick, MD
<u> </u>	permit, Depart Import eny inj once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility	ral Home s	and Crematory, P.A.
n	8258		self. Kellin	212 West Old Liber	tv Kd. Wi	ntield, MD 21784
	. 40		23a. Part1. Enter the dis-ase, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.			
	Physician		Immediate Cause (Final	- 1 1		Onset and Death
	/Medical			- Sthy Almio		
	Examiner		Due to (or as a consequence of):	, ter Disease		
		<u></u>	Sequentially list conditions, Due to or as a consequence of the conditions of the c	1 tery Ullerk		
	sit ad	Examiner	d any landing to immediate cause. Enter Underlying Cause (Disease or injury			
	ecut and -tran	can	that initiated events c.			
Š	cate be executed physician and the burial-transit	<u>m</u>	Due to (or as a consequence of):			
2/60	ate b nysic he b	dlcal	d			
	ntifica ng ph as t	Med	IF FEMALE			
X D	death certifi e attending id for use as	hysician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1	Textonia		23d. Date of delivery
מ	deat e att	icie	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
j.	by the	hys	9 ☐ Unknown			
<u>,</u>	w requires that the death certific been signed by the attending p should be detached for use as	₾.	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
as,	sign sign d be	d by			1 ☐ Yes	2 No 3 Probably 4 Øunknown
	need houl	ompleted				
d)	a si s	du			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	Thate page	Co			performe	
VII all	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	
>	S S D	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 Residen	ce 6 □Other (Specify)
			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Month, Day Year) 28b. Time of Month, Day Year) 28b. Time of Month, Day Year)		28d. Describe how	injury occurred
0	th. : Aft	et e	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
DIVISION	or Attending after death, Director: Afte in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Stre	et and Number or Rural Route Number,
	in the case of the	erti	4 Homicide building, etc. (Specify)		City or Town,	State)
_	spite ours ierei fillec	O	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deat	h occurred at the time, date and class	and due to the service	sa/s) and manner as stated
	To the Hospitel or within 24 hours after to the Funerel Discompletely filled in	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	e and place, and due to the cause(s)
	thin thin the mple	Mec	29b. Signature and title of certifier	29c. License number	200	I. Date signed (Month, Day, Year)
	/		2M VIII 11	Mn - F	NYLAW 2	a Sala (P
			Illich // laft	041378		00/06/00
12	, ,		30. Name and address of person who completed cause of death (Item 23a) (Type,			,
)			Michael W. Costello, MD 1564 Opossum	town Pike, Freder	ick, MD 21	1702
	Sta		31. Date filed (Month Pay, Year) 2005 32 Registrar's Signature	and i	·	
	Registr	ar	THE U I COUL There is to			

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item#5, per INF, G844, 6/15 (25) in Cate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jones 4:44 PM **Physician** 2005 May Eleanor n /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita more HOPKINS Johns 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 ∏ F **Funeral** Days Yrs. JUNE 28, 1936 NY 095.30.0573 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show s 23a or 28e-f show 1 ☐ Yes 2 ☐ No Director MONTICELLO WHITE IN the 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 47960 202 ROYALWOOD DR Items 23a Completed by Funeral be filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 1 Never Married XX Married Baltimore, Maryland 21215-0036 ŏ Specify: 3 Widowed 4 Divorced WHITE "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) treumetic event, the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY JUNIOR COLLEGE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental GRACE MARGULIES ABRAHAM OSTROW ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 202 ROYALWOOD DR MONTICELLO, IN 47960 PAUL JONES if of Health other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 ☐ Burial 2√√Cremation 3√√Nemoval from State
1 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. MILLER-ROSCKA F.H. 5.10.2005 MONTICELLO, IN 21. Signature of Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME PABURNIE, MD 21061 GREGORY KINK conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buy one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or or heart failure. List Immediate Case (Final disease or condition resulting in death) 4 days Brainstem Stroke Enysician /Medical **Examiner** thrombosis Basilar arten Sequentially list conditions, Tany, bearing to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ng physician as the burial Box 68760 Physician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physicien: 26. Place of Death Check on one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA 1 🗌 Yes 1 Impatient 2 ER/Outpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a Hospitel **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Junju Bubly MD, PhD RES-000 May 5 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore, MD 21287 0 Jennifer L.Berkeley 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 9 2005 Registrar

	_ 1	For Stata Registrer	State of Maryland / I	Department Certificate				Reg. No.		15521
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	ordan				2. Date of Dea Month	Day	Year 2005	3. Time of Death
Examin	er	ta. Facility Name (If not institution, give st	PITAL	GLE	N BURNI		8. Date of Birti	AN	INE ARI	JNDEL lace (State or Forei
Funeral Director		5. Social Security Number 6. Sex 218.84.7896 XX Usual Residence of Decedent	7. Age (In yrs. last bi		Days Hours	Min.	OCT 12	r, Year)	Coun	ENGTON, D
illed within 7.2 hours are bean with the maryana. Hygiene, ther than "natural", or Itams 23e or 28e-f show ant, the Medical Examinar must be rediffed at	ctor	10a. State 10b. County MD ANNE ARUNT	DEL GLEN B		ode.			10d. Inside City Limi 1 □ Yes 2 □ N XX		
9 or 2		10e. Street and Number			.061			rog. Okizen c	USA	uy.
to Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23e or 28e-f show or other traumetic evant, the Medical Examinat must be rollified at	by Funeral	9 LINCOLN AVE 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decede If Yes, specifi	nt of Hispanic C y Cuban, Mexic	an, Puerto I	cify Yes or No- Rican, etc.)		lace - Americ lack, White,	
ne. Ihan "natural Iv Medical Ex	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16a	a. Decedent's Usual (Give kind of work life, DO NOT use	Occupation done during mo retired)	ost of workii	ng		Business/Ind	dustry
nd Mental Hygie marked other I imetic evant, III	Be	10 17. Father's Name (First, Middle, Last) unk		FOREM	unk		(First, Middle,	Maiden Sum		
Ith and 27 is ma r traum		19a. Informant's Name/Relationship (Typ. TINA JORDAN		b. Mailing Address (Code)
Department of Health Important: If itam 27 any injury or othar tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	1	of Disposition (Name ery, crematory or oth CREMATO	er place)	5.9.2	eate 2005		n - City or To	
Departn Imports any inju once.		21. Signal uneral Service Licens	MOI148) FINK FU 426 CRA	Address of Fac INERAL H IN HWY	IOME, SW GL	P.A. EN BURN	IIE, MI	2106	1
Medical bhysician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, tank Lading to initially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	o of):	0					
e attending od for use a	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ⊟Ectopic pre 5 □ Other (spe					Date of delive	ery Day Year
S 9	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying ca	use given in Pai	rt I.		obacco use c ⁄es 2□No		ne cause of death pably 4 Dunkn
rtificate has been si stor, page 2 should b	Completed						24a. Was autor perfo 1 Yes		prior to co- death?	psy findings avail mptetion of cause 2 No
n. After this ce funeral direc	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 W No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year)		Other: 4 ic. Injury at Work?	Nursing Ho	n (Check only on me 5 ☐ Resid 28d. Describe I	dence 6 🗆 ((y)
Direct Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				City or To	vn, State)		al Route Number,
a Funaral letely filled	edical	29a. Certifier (Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred a and/or investigation,	t the time, date in my opinion, d	and place, leath occurr	and due to the red at the time,	cause(s) and date and plac	manner as s ce, and due to	tated. the cause(s)
within 24 hours a To the Funaral I completely filled	Me	29b. Signature and title of certifier)		License numbe			29d. Date 919	ned (Month,	Day, Year)
			1/							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** HERMAN MAY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDAZISTOWN BALTIMORE NORTHWEST HUSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | J. (Month, Bay, Year) 9. Birthplace (State or Foreign Decountry) Lvania 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ⊓M 2 □ F 162-32-1016 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-1 show in then "natural", or Items 23a or 28e-f show the Modical Extendrer must be notified at 1 ☐Yes 2 ☐ No Baltimore Director Maryland Reisterstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 52 Reisterstown Rd. 21136 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Government other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Herman R. Kresh Anna A. Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Kresh - brother 1976 Drexel Ave. Lancaster, Pa. 17603 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. May 10,2005 Owings Mills, Md. `4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Chapel P.A. 21. Signature of Fyneral Service Licensee Ello Here 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 minutes Cardiopulmona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): intravoscule dissemented the burial-tran Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 200 No 28 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00059736 2005 Question 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATSON NORTHWEST (tOSPITAL 5401 POAD COURT DEBURAH M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 09 Registrar 2005

			For State Registrer	State of Maryland	-	tment of He		ental Hygie Reg.	601	15	15523
	0		Decedent's Name (First, Middle, Last)	1				2. Date of Death		- 1	3. Time of Death
П	Physicia		Joseph	- Kaster	_			Month	Day	Year	2300 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		4c. County	of Death	
Н		•	Coastal tospic	ce at The Le	ske	Salis	sbury		Lui	com	ico
	Funeral		5. Social Security Number 6. Sec		t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yo	ear)	9. Birthplac	ce (State or Foreign
	Director			^{2M 2□ F} 78	Yrs.	Days		June 23,	1926		sylvania
	pu 🛊	-	Usual Residence of Decedent 10a. State 10b. County	10c City T	Town or Loc	ation				100	1. Inside City Limits
	sho	ö	Maryland Worceste	1	rlin						1 ☐ Yes 2 ☐ YNo
	28a-f	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of W	/hat Countr	2
	with the or		_								
	eath	era	5 Dinghy Court	12. Was Decedent Ever in U.S.	13. W	21811	panic Origin? (Spec		Inited 14. Race	State - American	
·0	fter d	Funerai	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	lf.	Yes, specify Cuban	, Mexican, Puèrto R.	ican, etc.)	Black	k, White, etc	3.
93	urs a	þ	3 Widowed 4 Divorced	If Yes, Give 11 Year or Dates:	1	☐ Yes 2∏ No	Specify:		Specify:	Whi	.te
9	be filed within 72 hours after death with the Maryland ital hygiene. dother then "naturel", or itams 23a or 28a-f show event, the Medical Exer; it are routhed at	Completed	15. Decedent's Edu (Specify only highest grad	cation (completed)	16a. Decede	ent's Usual Occupat	tion uring most of working	16	b. Kind of Bu	siness/Indu	stry
2	thin in Maria	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	ing most or working				
2	ygien ygien yer th	Ç	12	6	Accou					_	inty Gov't
pu	be fill d oth even	Be	17. Father's Name (First, Middle, Last)	77			18. Mother's Name (_	
$\frac{1}{2}$	ould Men Parke	ပို	Stephen		ster		Maria			Gerz	
Jar	12 sh n and r Is m	6	19a. Informant's Name/Relationship (T)			·	nd Number or Rural				ode)
e,	1 and Health	3	Mrs. Theresa C. Ka			gny Court ition (Name of	, Berlin,		nd 218		n State
סר	in its		1√2 Burial 2 ☐ Cremation 3 ☐ F	Removal from State cem	etery, crem	atory or other place)				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or itams 23a or 28a-1 show appringury or other traumatic event, the Madical Exercited met must be rediffed at Once.		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 			y Memoria					aryland
Ba	perm Depa Impo eny i		AIII	n Brian	T. C	hisholm F	uneral Se	rvices	of Dula	iney V	Valley, P.A
			23a. Part1. Enter the disease, or comp	lications that caused the death.			nia Road, , such as cardiac or				Approximate
г	Dhanistan		shock, or heart failure. List only o	ne cause on each line.	in-	1: +	11.0.	n 1 -		Ç	nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequer	nce of):	15 Mars	Meleino	7190			Tryears
h	Examiner					U					
		Jer	if any, leading to immediate	b Due to (or as a consequer	nce of):						
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Ö,	e exe	Ĕ	resulting in death) Last	Due to (or as a consequer	nce of):						
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9	n certific anding p use as	Me	IF FEMALE:	020 16 100 0140000 06 0100000							
Вох	eath certifi attending p I for use as	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1☐Live birth 2☐Fetal do	eath 3	Ectopic pregnancy			23d. Dat Moi	e of delivery nth D	y Day Year
P.0.	the s	yslc	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of deal 9□ Unknown	m 5	Other (specify)					
	The law requires that the death certific the has been signed by the attending Forage 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions co	entributing to death but not resulti	ing in the un	derlying cause give	n in Part I.	23e. Did toba	cco use conti	ribute to the	cause of death?
Vital Records,	uires sign ld be	d b					- 111	1 🗆 Yes	2 No	3 🗆 Probab	bly 4 Unknown
100	w require been si should b	Completed						24a. Was an	24b. V	Nere autops	sy findings available
Re	he lav e has age 2	mc						autopsy performe	ed?	death?	pletion of cause of
ta	icien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death		No 1	☐ Yes 2	MO No
	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 Inpatient 2 EF	R/Outpatient	3 □ DOA Othe			ce 6 □Oth	er (Specify)	
0	ding Ph h. After thi funeral		27 Manner of Death Natural 5 Pending	28a. ate of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at 2	Bd. Describe how	injury occurr	ed	
ioi	Attending r death. sctor; After y the fune	atic	2 Accident investigation				'es 2□No				
Division of	or Attend after death Director; /	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,		er or Rural I	Route Number,
Ω	urs af urs af urel D										
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director; After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier Check only one)	ysician: To the best of my knowle liner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and ma e and place, a	nner as stat and due to t	ted. he cause(s)
	To the within 2 To the complet	Mec	29b Signature and title of certifier	and mariner stated.		29c. License	number	290	d. Date signed	d (Month, D	ay, Year)
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	1		30. Name and address of person who d	completed cause of death (Item 2	23a) (Type. I	Print)		0	,		
İ	D		DAMID COLAKIN	OD CHASTAL I	405PK	E PO	Box 173.	3 Sept	Man	nur	21802
• •		ate	31. Date filed (Month Asy, Year)	32. egistrar's Signatur	8x 1	and?	7 1		()		
	Regist	rar	13 b A 11 tt	103 January	19						

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State of Maryland / Department of Health and Mental Hygiene

	1 - State All Registrer	nend Item 17,18 ne (First, Middle, Last)	per FH	,0043	Cei	tificate	of D	eath	1 2	. Date of Dea	leg. No.	05	3. Time of Death
Physician /Medical	Lentz	L, Man	e Mar	ie /	Ann	Lentz				Month 05	O /	Year 05	7:43 P M
Examiner	4a. Facility Name	(If not institution, give :				4b. City, To					4c. Cour	ity of Death	
Funeral Director	5. Social Security 218-32-		7. Ac	ge (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs. 8 Min.	Date of Birth (Month, Day 01-25	, Year)	9. Birthr Cour Ba	place (State or Foreign ofty) hmbre, mb
ene. than "natural", or items 23a or 28a-1 show ha Neulcal Examiner must be notified at ompleted by Funeral Director	Usual Residence 10a. State	of Decedent 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
s or 28a-f show be notified at Director	MD	Baltimo	re	Bal	timor	e							1 ☐ Yes 2 X No
be notified Director	10e. Street and N	umber				10f. Zip C	Code				10g. Citizen o	of What Cou	ntry?
23a unith rai	9751 E	Bird River					220				U.S.		
ar, or items 236 caroliner count by Funeral		rried 2 Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Decede If Yes, specif 1 ☐ Yes 2	_	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Spec	ace - Americack, White,	
2 44		15. Decedent's Edu	cation		16a. Deced	dent's Usual	Occupat	tion			16b. Kind of		
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itsm 27 is marked other than "natu other treumatic event, the Medical To Be Completed	r	(First, Middle, Last)	John Ed	lward l	sisner	2		18. Mother	s Name (First, Middle,	1		Crosby
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uthe othe	20a. Method of D	sposition	_	20b. Pla	ce of Dispo	sition (Name	9 of		Da	te	20c. Locatio	n - City or T	own, State
ant: If		2 □ Cremation 3 □ F 5 □ Other (Specify)		Dula	ney V	alley	Mem	.Gd.0	5/04	/2005	Timon:	ium, M	Maryland
Importent: If Itsm 27 is any injury or other tre once.	21. Signature of	uneral Service Licens	esadn	5		2. Name and							Home, P.A and 21087
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igned by be detac by Phy	Part II. Other sig	nificant conditions co	ntributing to death	but not result	ting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco use c	ontribute to	the cause of death?
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page 2 should										24a. Was			opsy findings available ompletion of
ε e E										perfo	rmed2 2 No	death?	2 No
director, pag	25. Was case re- examiner?		Hon	1E H	6SP1C	E	11.2	-	of Death	(Check only o	ne)		
La di	1 🗆 Yes 2	∑ INO	Hospital: 1 ☐ Inpat			nt 3 DO	_	4 🗆 Nui	-	e 5 Hesio			ify)
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the ca	2 Accident	6 Could not be		njury - At hon	ne, farm, st					3f. Location (S	Street and Nu	mber or Aur	al Route Number,
dinb dinb	4 🗌 Homicid	9 Gereimined	building,	etc. (<i>Specify</i>)	1					City or Tov	vn, State)		
	29a. Certifier	1 Certifying Phy 2 Medicel Exam	ysicien: To the besiner: On the basis and manner:	of examination									
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To the Funeral Direct completely filled in by Medical Certifi	one)	nd title of certifier	1		1	29c.	License	number			29d. Date sig		
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To the Funeral D completely filled in Medical Cel	29b. Signature a	nd title of certifier				H	000	008		mo	05-1		

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es McCa	all	AGRETICI ILE	State of Maryland		irtment of Hea			ene g. No.2005	15525
	sician	1. Decedent's Name (First, Middle, Last)		i	McCall		2. Date of Death Month May 02	Day Year	3. Time of Death 5:50 P M
	edical miner	4a. Facility Name (If not institution, give subjects to the subject of the subjec	· ·		4b. City, Town, or Loc Baltimore	cation of Death	riay 02	4c. County of De	
Fune Direc		5. Social Security Number 6. Sex 218–60–6066		ast birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-19-	9. B -53	irthplace (State or Foreign Country) Md.
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Md N		Town or Lo					10d. Inside City Limits X Yes 2 No
with the	I Direc	10e. Street and Number 1020 Hollins Stre	et		10f. Zip Code 21223		10	g. Citizen of What C	Country?
DESILIMOTE, INIGITY IGHT A LAID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 Is marked other then "neturel", or Itams 23e or 28e-1 show any initiar or other treatment is event to the first the first the first that	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa f Yes, specify Cuban, M □ Yes 2X No S	anic Origin? (Spe Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland ZIZI3-0030 d 2 should be filed within 72 hours aft th and Mental Hygiene. T? Is markad other them "neturel", or trannalic aven it is Marice Erg.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. l	dent's Usual Occupation kind of work done during DO NOT use retired)	n ng most of workir	ng 1	6b. Kind of Busines	
dillo 6.	To Be Cor	17. Father's Name (First, Middle, Last)		La		. Mother's Name	(First, Middle, M		Baltimore
and 2 shoulest the mark and Miles and Miles and Miles and Miles are traumating		19a. Informants Name/Berationship/	Mife Wife		g Address (Street and 2 E. Lomba			. 1	
Deficiency (E.) Demit. Pages 1 ar Department of Hea Important: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place) ount Cem.	5-9	-00	oc. Location - City o	
permit. Departi	900G	21. Signature of Funeral Service License	Wanes		Name and Address o	East		E. North	21202 Ave.
Pnysici /Medio Examir	cal	23a. Part1. Enter the disease, or dompli shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death ne cause in each line. Due to (or as a consequ	Lewt	- / - 1	o Work (c	r respiratory arres	st,	Approximate Interval Between Onset and Death
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ne death certifi the attending	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnat 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year
quires that the signed by	à à	HT I Car as As A	tributing to death but not resu	ılting in the u	nderlying cause given it	n Part I.	23e. Did toba	Δ.	to the cause of death? Probably 4 Unknown
	Comp						24a. Was an autopsy perform 1 Yes 2	ed/2 prior to death?	autopsy findings available completion of cause of os 2 No
Physicien: The this certificate	Be	examiner?	lospital:		Lau		(Check only one		
ding Phys	tion: 1	IX 163 2□140	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury at Work?		ne 5 Resider 8d. Describe hov	nce 6 Other (Sp v injury occurred	ecity)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,
the Hospitel or in 24 hours afte the Funeral Directory filled in	edicai	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my knowner: On the basis of examinat and manner stated.		estigation, in my opinio	on, death occurre	d at the time, dat	te and place, and du	ue to the cause(s)
To the within 2 To the	S	29b. Signature and title of certifier	0		29c. License nu OCM			d. Date signed <i>(Mor</i> ay 03 200.	
6	9	J LAMANT LACKE	mpleted cause of death (Item	23а) (Туре,	Print) 111 Penn	Street			
Rec	State	31. Date filed (Month Day, Year) 200	Registrar's Signal	иге	ulle 3				

			For Stata Registrar	State of M	aryland / Der	partment of leartificate of			iene	05	120	596
	9.		Decedent's Name (First, Middle, L.	a <i>st)</i>				2. Date of Dear	th		3. Time of	Death
	Physicia /Medic		Dorothy Mae Mi	nor				Month May 4,	Day 2005	Year 9	:17	АМ
	Examin		4a. Facility Name (If not institution, g	ve street and number)	1	4b. City, Town,	or Location of De		4c. County	of Death		
			Carroll Hospit			Westmi			Carr			
ı.	Funeral			Sex 7. Ag 1 □ M 2 ▼ F	ge (In yrs. last birthda 7.6 Yrs.	y) If Under 1 Year Months Days		in. (Month, Day	Year)	9. Birthplac)	r Foreign
Н	Director		218-46-0335 Usual Residence of Decedent		76 Trs.			May 16,	1928	Maryl	and	
	ryland how		10a. State 10b. County		10c. City, Town or	Location				10d.	Inside Ci	•
	e Ma 3a-1 a	cto	MD Carrol	<u>L</u>	Westmins	ter					1 🗌 Yes	2 No
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	s 23e	erai	2580 Cross Section 11. Marital Status	n Road	Ever in U.S. 12	21158	Hispanio Origin?	(Specify Yes or No-	United	States - American		
' 0	72 hours after death with the Maryland Instural, or Itams 23e or 28a-f ahow Jical Examirer oust be mailfed at	Funeral Director	1 ☐ Never Married 2 ☑ Married	Armed Forces?	?	If Yes, specify Cub	oan, Mexican, Pu	erto Rican, etc.)		k, White, etc.		
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an	id be ental ked o	To Be	Oscar Frank Gues	•				Emma Sch		-,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 la marked othar than "netural; or Itams 23e or 28a-1 ahow apprintury or other traumatic event, It's Marical Examiner cast be mailted at once.	Ě	19a. Informant's Name/Relationship		19b. Ma	iling Address (Stree	·	Rural Route Number		State, Zip Co	ode)	
Ž	alth a alth a 27 le		Daniel W. Minor,	SrHusband	258	O Cross S	ection F	Road West	minster	, MD	2115	8
ore,	of He of He litam		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	□ Pomoval from State	20b. Place of Dis	position (Name of rematory or other pla	ice)		20c. Location -		, State	
<u><u>Ĕ</u></u>	Page ment: It ant: It	10,	' 4 □ Donation 5 □ Other (Spec		' [rroll Cre		2005	Winfiel	d, MD		
3alt	permit. Departi		21. Signature of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility	eral Home	& Crem	atory.	PA.	
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١,			23a. Part1, in or the disease, or co shoot, or heart failure. List on		d the death. Do not e	inter the mode of dy	ing, such as card	liac or respiratory arr	est,	Ini	oproximate terval Bet nset and [ween
	Pnysician /Medical	9 1	Immedia e C (use (Final disease or c ndition resultin vin eath)	a		615105 1	NAIL III	140 caed i Al	ハライル	Chr.	2440	3000
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Вох	death certific e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	су		23d. Date Mor	of delivery oth Da	y Y	Year
o.	D 0 D	ysic	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant a 9□ Unknown	it time or death s	i ☐ Other (specify) _						
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Physician/Me	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did tol	oacco use contr	ibute to the c	ause of d	eath?
rds	w requires that been signed b should be det	q pe	CORONARY A	chear dis	rese			_ 1 □ Ye	s 2 No	3 🔲 Probabl	y 4 □U	Jnknown
CO	s bee	ojete	DILATED ISC	Henic C	cassi on	y Opathu	1	24a. Was a		Vere autopsy	findings a	available
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× ×	Physicien: r this certific ral director,	၉	1 ☐ Yes 2 XNo	Hospital: 1 Inpati		BIIL 3 DOA	and the second second	g Home 5 ☐ Reside	ence 6 □Othe	er (Specify)		
n c	ding P h. After t funera	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury	/ Wa		28d. Describe ho	w injury occurre	ed		
isic	Attending r death. actor: After by the fune	icat	2 Accident investigate 3 Suicide 6 Could not	ho l	iunc - At home, farm]Yes 2 □No	28f. Location (St	reat and Numbe	er or Rum I Di	outo Numi	bor
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	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	O	29a, Certifier 1 Certifying I	hysician: To the best	of my knowledge, de	ath occurred at the t	ime, date and pla	ace, and due to the ca	ause(s) and mar	nner as state	d.	
	tha Ho hin 24 t tha Fu npletely	edicai	(Check only 2 ☐ Medical Ex- one)	aminer: On the basis of and manner st	of examination and/or tated.	investigation, in my	opinion, death or	ccurred at the time, d	ate and place, a	ind due to the	e cause(s))
	To tha within 2. To tha I complete	M	29b. Signature and title of certifier			-	se number		9d. Date signed			
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ì	1		30. Name and address of person wh		death (Item 23a) (Typ	e, Print)	1.10	0	-0 :		.1 .	(1,000)
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MARGARET MCCORMLEY

05-03043 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brandon M. McCurdy State of Maryland / Department of Health and Mental Hygiene tate Unpend Item 23a,27,28a-f per me CS43 5-16-05 tas
Registrar Registrar Reg. No. R.JD 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Oate of Oeath May 02, Year **Physician** 2005 BRANDON MICHAEL WEBB MCCURDY 0952A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1720 Red Oak Road Parkville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 4/2/1985 Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 3 M 2 □ F 220-08-3069 20 Vrs Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show treumatic event, it e Modical Examiner must be notified at MD BALTIMORE PARKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With The USA 21234 9279 THROGMORTON ROAD APT. E Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) STUDENT COLLEGE 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BRIAN MCCURDY REBECCA WEBB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN MCCURDY/FATHER 9279 THROGMORTON RD. item 27 APT. E PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of h 1

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If any Injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK 5/7/2005 HILLENDALE, MD 21. Signa ur of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician Methadone Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4 Pregnant at time of death g detached 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an 1 Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence XXOther (Specify) (Scene) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 X Yes 2 □ No filled in by the funeral 28a. Date of Injury 5-2^M05 Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 9:47 found a Division 1 Natural 5 Pending investigation found 2 Accident Director: Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1720 Red Oak Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide found at home To the Hospitel within 24 hours a To the Funerel L Parkville, Maryland 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)
May 03, 2005 29b. Signature and title (a) certifier 29c. License number

State Registra

31. Date filed (Month, Da

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30. Name and address person who completed cause of death (Item 23a) (Type, Print)

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1 M.D

egistrar's Signature

OCME

111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23, **Physician** Day 2005 Year Margaret Ann Badger Miller 10:57 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunbridge Care and Rehabilitation Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer Aug 29, 19 **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 🗓 F 198-05-1131 **Director** 86 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Modical Examinar Invat Le notified at once. 10c. City, Town or Location 10b. Count 10d. Inside City Limits Cecil E1kton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? គ 1 Price Lane 21921 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: à 3 X Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Price Lane Elkton, MI Sunbridge Care Center MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 ₩ Other (Specify) in state 21. Signature of Euro al Service Licensee Ronald S Walle State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 70022 art1. Enter the disease, or complications that caused th nock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) sclerotic **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced in the cause) Examiner Due to (or as a consequence been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 1 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) older 5 MD D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St, Sult 3B, Elkten MD21921 118 North 31. Date filed (Month 2. Registrar's Signature 9 2005 State

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Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND TEM #5 PER FH C844 6/ CONTEST OF Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year APRIL MILLER 2005 $11:00A^{\vee}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOUSEHOLD OF ANGELS NURSING HOME CROFTON ANNE ARUNDEL 5. Social Security Number 229-23-3890 230-14-8856 Usual Residence of Decedent If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M Director 78 JAN 21, 1927 VA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show troumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD ANNE ARUNDEL CROFTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a 2163 DAVIDSONVILLE RD 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes YNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3₩idowed 4 Divorced Specify naturel WHITE XX Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES/CONSULTING PAINT COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT P. WHEELER JETT WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i PATRICIA PILSON 100 EAST OCEANVIEW AVE. APT. 707 NORFOLK, VA 23503 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State ō <u>=</u> ŏ permit. Page Department (Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) FOREST LAWN CEMETERY NORFOLK, VA 21. Sign Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY FINK K. M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULLICHARY 20 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? CRONARY autopsy performed Division of Vital 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death Check onl one examiner? 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatr Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fune
completely fi 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) - E 2004 DOG61776 29, 2005 ARRIL 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLF MD SCITTE 400, ANNAPOLIS, MARYLAND, 116 DEFENSE HIGHWAY 31. Date filed (Month, Day, Year) State 2005 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7:20 PM DUANE ORLANDO MORELAND 1a> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours Yrs. Director 216.16.3502 81 AUG 25 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1454 FAIFIELD LOOP RD 21032 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXIVes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2□ No **XX** 1 🗌 Yes ₩Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 TRUCK DRIVER CONTRACTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be To JOSEPH KRONSBERG FLORENCE C. VAN ARMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JUNE L. BIDEN 800 MIDDLEBROOK RD. GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Himportant: If Ite any injury or of Once. 1 Burial Cremation 3 Removal from State
4 Donation 5 Other (Specify) BAYVIEW CREMATORY 5.6.2005 BALTIMORE, MD 21. Signatur o Funeral Servic 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part1. Inter the disease, of shock, of heart failure. List Fank MO1148 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Myocardia Examiner Sequentially list conditions, any, leading to in reclaim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 2 No 1 🗌 Yes 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🗖 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manny of Death 1 atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number With IA M.D. 041365 h 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) George E. Wicks M.D. 301 Hospital Drive Glen Burnie Maryland 21061 Jeorge 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 9 2005 Registrar

			1 - For State Registrar	State of	Maryland		artment			and M	-	giene Reg. No.) (IE	15500
	Dhusisi		Decedent's Name (First, Middle,		-						2. Date of De		Year	3. Time of Death
Н	Physici /Medio	cal	PAMELA	PHI PPS							APRIL	20an	2005	
А	Examir	ner	4a. Facility Name (If not institution,		ber)				Location of				ounty of Death	
	Funeral		Genesis Randal 5. Social Security Number	6. Sex 7	. Age (In yrs. la:	st birthday)	If Under	Year	llsto If Under	24 Hrs.	8. Date of Bir	th	altimo	nplace (State or Foreign untry)
Ц	Director		220-38-4571	1 □ M 2 🂢 F	62	Yrs.	Months	Days	Hours	Min.	June 10	0, 194	+2 V	irginia
	land ow		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	tor	MD Carı	:o11	W	estmi	nster							1 ☐ Yes 2X No
	ith the or 284	Director	10e. Street and Number				10f. Zip (Code				10g. Citizer	of What Cou	untry?
	s 23a	rail	1305 Uniontowr						21157				USA	·
	iter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Ford	lent Ever in U.S. ces? ? (XNo	. 13. \	Was Decede f Yes, speci	ont of Hi fy Cubai	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	14.	Race - Amer Black, White	
1215-0036	hours after death with the Maryland turel: or Items 23a or 28a-f show Exacting count be rediffed at	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dat	41.		1□Yes 2	X) No	Specify:			Sp	pecify: W	hite
<u>,</u>	"natu	Completed	15. Decedent' (Specify only highest	s Education grade completed)		(Give	dent's Usual kind of work	done d	uring most	t of worki	ng	16b. Kind	of Business/l	ndustry
	within 72 ene. than "nai	duic	Elementary/Secondary (0-12)	College (1-4	4or 5+)		acher	e retired)				o d	ucatio	_
andz	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or items 23a or 28a-f show event, tra Madical Exactinat must be notified at	Be Co	17. Father's Name (First, Middle, L	ast)			dener		18. Mothe	r's Name	(First, Middle,			.11
Var		To B	Kenneth Dame							Mar	tha Phi	llips		
Mar	12 sho		19a. Informant's Name/Relationsh								i Route Numbe	•	own, State, Zi	ip Code)
d5	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other treumatic		Neeta Falconer/ 20a. Method of Disposition	sister	20b. Pla	ce of Dispo	sition (Nami	e of			ck, MD		ion - City or T	own. State
Ē	Pages ent of nt: If if		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp		tate cen	netery, cren	natory or oth	ner place	9)					,
Baltimore,	permit. Pages 1 Deportment of H Importent: If Ite any injury or ot 90000.		21. Sign thus of Euneral Service L Ronal of S		texor	St Ba	Name and Late A	Addres nato	s of Facility Omy B	oard 2120	655 W.	Balt	imore	Street
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F	Physician		Immediate Causa (Final disease or condition			Se	Reno	re	DU	oea	ne			Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseque	nce of):		- 1	£a	./	2 6			7.70 7.60 67
		er	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	as a conseque	ence of):	Иес	ert	V C1	1100				movield
	cuted nd ransit	Examine	that initiated events		AR DIO									moncy
ģ	oe exe cian ar ourial-t	I Ex	resulting in death) Last	Due to (o	r as a conseque	ence of):								
68/60,	ures that the death certificate be executed signed by the attending physician and doe detached for use as the buriat-transit	dicai		d										
XO	n certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d	. Date of deliv	rery
מ	s death he atter ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2∏Fetald nt at time of dea vn		Ectopic pre Other (spe			-			Month	Day Year
л 5	hat the id by t Jetach	Phy	9 ☐ Unknown Part II. Other significent condition			ing in the us	adoshina sa	150 01110	n in Port I		230 Did to	abacco uso	contributo to t	the cause of death?
cords,	requires that the been signed by th hould be detachs	d by		- John Batting to do	ar but not rosult		idonying ca	230 givo	ii iii aiti.					bably 4. Unknown
် ပ	law requir as been si 2 should l	Completed									24a. Was		4b. Were auto	opsy findings available
ב י	The ate h page	Com										rmed?	death?	ompletion of cause of 2 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Otha			(Check only o			
5	ral d	. To	1 Yes 2 No	28a. Date of	oatient 2 EF	R/Outpatient 8b. Time of		c. Injury	- IVUI		ne 5 Resid			fy)
0 1	nding ath. r: Afte e fune	atior	t Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month,	Day Year)	Injury	м	Work	? es 2 □ N					
DIVISION	r Atte ter dea irecto by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Place o building	f Injury - At hom g, etc. (Specify)	ie, farm, stre	eet, factory,	office		2	28f. Location (S City or Tow	Street and N vn, State)	umber or Rur	al Route Number,
ָ ב	pitel o		202 Cartilian 4 The stitutes											
	to the Hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying (Check only 2 Medicel E	Physician: To the b xaminer: On the bas and manne	is of examination	n and/or inv	restination i	n mu ani	inion dost	h occurre	ad at the time	ala baa atab	an and due to	a Alba antina/a)
	To t	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date si	gned (Month,	Day, Year)
			Spip	HMD	-1.3 "		I	00	531	50		APRI	(27	p 2005
			30. Name and address of berson w	no completed cause A (A Col	or death (Item 2	3a) (Type, 1	Print)	g en	TY a	CAI	RAN	DALL	570 Wh	121133
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2	005 Reg	gistrar's Signatur	Soon	r)				,			Day, Year) Possible Course (S) Day, Year) Possible Course (S) Day, Year) Possible Course (S)

DHMH 17 Rev 1/2001

			OA-A-	partment of Health and Mental ertificate of Death	2005 15500
			Hegistrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. 3. Time of Death
	Physic		Marick Proctor	Month May	Day Van
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Southern Maryland Hospital	Clinton	Prince Georges
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. June	of Birth 9. Birthplace (State or Foreign County) 9. Birthplace (State or Foreign Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	
	Maryl f sho	ō	Maryland St. Mary's Chaptic		10d. Inside City Limits 1↓ Yes 2 □ No
	28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with		22580 Mill Creek Drive	20621	USA
	deat ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian,
98	or the	y Fu	1 Never Married 2 Married 1 Yes 257 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	
Ö	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show disal Examinat he notified at	d by	3 Widowed 4 Divorced Year or Dates:		American Indian
Maryland 21215-0036	d within 72 ho jiene. Ir then "natu Ire Madical	Completed	15. Decedent's Education (Specify only highest grade completed) (Gift	edent's Usual Occupation le kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	I within liene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	lled Laborer	Brandywine AutoPar
힏	othe ent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	
<u>la</u>		10 E	Charles W. Proctor	Eulalia G. 1	Fenner
lan.	2 should be and Mental Is marked eumetic ev		19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code) 20613
	12 th		10-17	35 Woodville Rd. Bra	ndywine, Maryland
Baltimore,	ges 1 a it of Hea if item or othe		ragration 2 Continuon 3 Chemoval non 3tate	ematory or other place)	20c. Location - City or Town, State
Ħ,	it. Pa rtmen rtent: njury			ers Cemetery5-9-05	Waldorf, Maryland
Ba	permit. Pages 'Department of H Importent: If ite any injury or ot once.		191 A	22. Name and Address of Facility dams Funeral Home, 1	
Ŋ,			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respirator	Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Massive Clre	brovascular acci	Onset and Death
П	Examiner		Due to (or as a consequence of):	brovascular acci	
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Temiation	
J	cuted nd ransit	Examiner	that initiated events		
Ö,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):		
8760,	hysic the bi	dical	d		
9 ×	leath certific attending p	/Mec	IF FEMALE:		
Вох	attene for us	Physician/Me	in the past is months:	Ectopic pregnancy	23d. Date of delivery Month Day Year
o.	that the de ed by the detached	ysk	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)	
م	that the	by Pr	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. D	tid tobacco use contribute to the cause of death?
rds	w requires been signi should be	q pe		1	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Records,	aw re	Completed		24a. W	fas an 24b. Were autopsy findings available
ž	The lay ate has page 2	mo:			utopsy prior to completion of cause of death? s 2 No 1 Yes 2 No
Vital	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	
	Attending Physicien: r death. sctor: After this certific. by the funeral director.	2	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatien		esidence 6 Other (Specify)
Division of	r Attending Phy er death. rector: Atter this by the funeral c	ertification:	27. Manner of Death 1 Anatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	be how injury occurred
ISIC	ttendi death. ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	a (Standard Muselman)
2		erti	4 Homicide determined building, etc. (Specify)	City or	n (Street and Number or Rural Route Number, Town, State)
	ospite hours inerel y fille	alC	29a. Certifier Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due to the	he cause(s) and manner as stated
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time	ne, date and place, and due to the cause(s)
	To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			A pere s.	DOD 60362	5-3-05
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Bowie MD	20.702
	Sta	0	31. Date filed (Month, Day, Year) 32. Destrar's Signature	DONIE MD &	20120
	Registra		MAY 0 9 2005		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3. Time of Death Day **Physician** Month DORIS 2005 SHOR May 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Year) JAN. 8, 1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛱 F 213-01-3279 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if itam 27 is markad other then "natural", or items 23a or 28a-f show injury or other traumatic evant, it is Modical Exercities must be notified at Be Completed by Funeral Director 1 Tyes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2518 SUMMERSON ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ¥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Mental ABRAHAM PEARLMAN anna SEIDMAN Department of Health and M Important: If itam 27 is marl any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 MIDFIELD ROAD - BALTIMORE, MD 21208 LINDA GROSS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM 05/06/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Edward 1 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON WODGICINS LYMPHOMA **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of). the attending physician and thed for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1☐Live birth 2 ☐ Fetel death in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RESPIRATION FAILURE PLEUMAL EFFUSION 2\12\no 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 BREAST CAREN 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To tha Funarai Director: the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number
D 2773 U 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, 0

DHMH 17 Rev 1/2001

State Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

6569 N. CHAMES ST. BATMONE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(suer

MAY 0 9 2005

31. Date filed (Month, Day, Year)

		1	State of Maryland / Depart 1- For Agents amend item #26 per ME g843 S #08		lental Hygie	4000	5535
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Lois Irene Seamens		APRIL :	8, 2005	10:23 PM
	Examin	er		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
	Funeral Director		5. Social Security Number 057-38-7266 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 9, 1	9. Birthp Count 1915 Ohi	
	Maryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local MD Montgomery Silver	stion		1	0d. Inside City Limits 1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	itry?
	s 23e	ral	149 Ritchie Avenue 11 Marital Status 12. Was Decedent Ever in U.S. 13. W	20910	acify Yes or No.	USA 14. Race - Americ	an Indian
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "neturel; or items 23e or 28e-f show other treumstic event, the Mudical Examinar must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto □ Yes 2 I No <i>Specify:</i>	Rican, etc.)	Black, White, Specify: whi	etc.
21215-0036	ithin 72 ho	Completed by	(Specify only highest grade completed) (Give killed Differentiary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation ind of work done during most of work O NOT use retired)	ing	. Kind of Business/Ind	
	Hygien Hygien Ther th	Co	12 0 man	18. Mother's Name	apa (First, Middle, Maid	artment co den Sumame)	mplexes
land	uid be f Aental H rked of tic eve	To Be	Clark Halverstadt	Ada Zimm	erman		
Maryland	d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "! treumatic event, the Med		, , , , ,	Address (Street and Number or Rura Ritchie Avenue Si			910
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other treu once.		20a Method of Disposition 20b. Place of Dispos	ition (Name of [atory or other place)	Date 200	. Location - City or To	wn, State
Balti	permit. Departm Importe any inju	İ		Name and Address of Facility ate Anatomy Board 1timore, MD 2120		altimore S	Street
8760,	Physician pe executed unding physician and physician and physician and are as the purial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	i Cardiovace	ular D	Seasl	Onset and Death
P.O. Box 68	death certific e attending p od for use as	by Physiclan/Medi		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Recoi	e las has	Completed			24a. Was an autopsy performed	prior to co	psy tindings available mpletion of cause of
/ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		h (Check only one)		
Division of Vital Records,	ng Phys fter this neral di	tion: To	1 ∑ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 27. Manner of Death 1 ☐ Natural 5 □ Pending 2 □ Accident investigation Hospital: 1 □ Inpatient 2 □ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		me 5 Residence 28d. Describe how	2 11 2	SCENE
Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, streen building, etc. (Specify)	et, tactory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	il Route Number,
	a Hospit 24 hour s Funere stely fille	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.				
	To the within To the comple	Me	29b. Signature and title of confider	29c. License number OCME		Date signed (Month, RIL 26, 2	
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	111 Penn Street	Baltimor	e, Marylan	d 21201
	. Sta Regist		31. Date filed (Month Pay, Year) 2005 32 Registrar's Signature	de)			

		1	State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2005 15536													36	
-	/sicia ledica	n	1. Decedent's Name (First, Middle, Last) Helene Smith									2. Date of Dea Month MAY	Day	Year 2005	3. Time of 7:00	М	
	amine		a. Facility Name (If not institution		4b. City, Town, or Location of Death					4c. County of Death							
			509 KENT CR . Social Security Number	6. Sex		7. Age (In yrs. last birthday)			GLEN BURNIE If Under 1 Year If Under 24 Hrs.			9 Date of Bird		ANNE ARUNDEL			
Fund Direct			511.24.1120		M 2 F	82	Yrs.	Months	Days	Hours	Min,	8. Date of Birtl (Month, Day APRIL			place (State of PA	or Foreign	
land	24	-	Usuel Residence of Decedent Oa. State 10b. Count	у		10c. C	ity, Town or Lo	ocation						1	0d. Inside C	ity Limits	
Mary I-f sh	Total I	ō	MD ANNE ARUNDEL GLEN BURNIE											Ì	1 🗌 Yes	2 No	
th the	E LICE	1	10e. Street and Number 10f. Zip Code										10g. Citizen of	What Cour	ntry?		
ath wi	d late	2	509 KENT CR 21060											USA			
er de:	ā	an 1	1. Marital Status	edent Ever in I	If Yes, specify Cuban, Mexican, Puerto					ecify Yes or No- Rican, etc.)	es or No- etc.) 14. Race - American Indian, Black, White, etc.						
136 rs aft	XBC	Dy L	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Giv Year or D	ates:		1 ☐ Yes 2 ☐ No Specify:					Specia	Specify: WHITE			
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Indoor then "natural", or Items 23e or 28e-f show	69	Completed by Funeral Director	15. Decede	nt's Educ			16a. Dece	dent's Usua kind of wor		ation	t of words		16b. Kind of E				
215 thin 7 e. e.	Med .	- Pie	(Specify only high Elementary/Secondary (0-12)		College (1	1-4or 5+)	life.	DO NOT us	se retired	unng mosi)	or work.	ng					
N 8 5 5	2	5	12				PROC	ESSOR						AX			
be fightly doth	even	မှ ¹	7. Father's Name (First, Middle							(First, Middle,	Maiden Sumai	iden Sumame)					
Baltimore, Maryland permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If item 27 is marked oth	natic	0	JOHN P. O'DON		an Orine)		10h Maili	na Addrasa	/Stroot s			LHEARN al Route Numbe	c City of Tour	State 7ie	Codel		
Man d 2 st d 2 st	traun		19a. Informant's Name/Relation KAREN ELLIOTT	isnip (<i>i yt</i>	oe, Print)			•				POLIS, N		, State, ZIP	(0006)		
1 an Healt	other	2	Oa. Method of Disposition			20b.	Place of Disp	osition /Nan	ne of			Date	20c. Location	- City or To	own, State		
Pages nent of nent: If its	y or o		Burial 2 Cremation		emoval from	State MD	VET CE	matory or o	WNSV	ILLE	5.6	2005	CROWN	SVILL	E, MD		
Baltimore, permit. Pages 1 a Department of Hec mportent: If item	声	1	21. Singly tyre Funeral Service		9.		1 2	NK FU	d Addres	s of Eacilit	Y	D 4				_	
m gg m	any i	1	K. GREGORY	FIN	K	MO1148						P.A. EN BURNI	E. MD2	1061			
Physic	ian		Immediate Cauce (Final disease or condition	or complications		tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory cause on each line.							Approximate Interval Between Onset and Death				
/Med Exami	ner		resulting in death)		Due to (or at a construence of): Chromic atomal fibrication 12									290	>		
P	Sit.	Examiner	Sequentially list conditions, Lany, loading to immediate cause. Enter Underlying Cause (Disease or injury	2	Dus to (or as a consequence of):								2000				
60, be executed	-tran	Xam	that initiated events resulting in death) Last	c	Due to (or as a consequence of):								act vi				
8760, cate be executed physician and	buria .	Ical E															
687 tificate ig phys	ts the	edic		0													
Box 68 death certifica	e esn	-	F FEMALE: 23b. Was decedent pregnant	23	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delivery				
O. B ne deat the att	ed fo	SICIS	in the past 12 months?		4 □ Pregnant at time of death 5 □ Other (specify)							M	Month Day Year				
P.O nat the	detached	ב ב	9 Unknown					W				220 Did to					
Se Se	peq .	λ _α	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown					
aw requ	2 sho	Completed		24a. W							24a. Was autop	vas an 24b. Were autopsy findings available prior to completion of cause of					
ت ة ي <u>.</u>	page	é										perfor	med?	death?	1?		
Vital sicien: T	ō		25. Was case referred to medic examiner?	26. Place of Death (Check only one)													
<u> </u>	77	0	1 ☐ Yes 2 ☑ No	Н			ER/Outpatie		<u> </u>			me 5 Pesid		Other (Specify)			
Jing After	funer	ation:	7. Mann of Death 1 Natural 5 Pending 2 Accident investigation		28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	M 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred					
Division at or Attending after death.	d in by th	Certification:	3 Suicide 6 Could 4 Homicide	d not be mined		of Injury - At ing, etc. (Spec		ne, farm, street, factory, office				28f. Location (Street and Number or Rural Route I City or Town, State)			al Route Num	iber,	
Division To the Hospital or Attent within 24 hours after deatl To the Funeral Director:	completely filled in by the	_	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.														
fo the vithin fo the	Idwoo		29b. Signature and title of certif	ier	27				29c. License number				29d. Date signed (Month, Day, Year)				
,- > ,-	,		0.9						D14136				May -2-2005				
. /	/	3	30. Name and address of perso	n who co	mpleted caus	se of death (Ite	em 23a) (Type	Print) D	ALJ	17 5	5. S	AW HOW	Cy F				
- 12	1		30. Name and address of person Swite 210	Cra	in T	owers	Gilos	n Bi	vs r	NR	Md	2106	1.				
Re	Stat gistra	e i	od Data Glad (Manth Day Van	9 20	32.7	egistrar's Sign		medis									

Gregory Tucker UNK 05-02954 05-02954 RPD

1295	04		110000						-		Legible.		
			1 - For Stete Registrar	State of Maryland		artment <i>rtificate</i>			Mental Hy		ODAM	f free pass	0 .
			Decedent's Name (First, Middle, Last,)		imoato	0, 50	, au 1	2. Date of D		1000 V/ 1/ 1/	3. Time of De	ath
	Physic /Medi		Gregory	Tucker					April	29, Da	2005 Year	0117 A	М
	Exami		4a. Facility Name (If not institution, give					cation of Death		- 4	County of Death		
			413 S Augusta Ave		111111	Balti		Hada Od Ha		N			
в	Funeral Director		5. Social Security Number 6. Sec. 15	7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of B (Month, D	irth lay, Year)	COL	place (State or Fo	oreign
			Usual Residence of Decedent						Dec. 18	,170	3 mai	ryland	
	anylan ahow	_	10a. State 10b. County	Δ.	Town or Lo	,						10d. Inside City L	
	Ba-1	ecto	mo Montgon	nery Ger	man							1 Yes 2	2 No
	with ti	Ē	10e. Street and Number 18531 Bayleaf	Way		10f. Zip 0	- /			-	izen of What Cou	ntry?	
	leath ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. 1			nic Origin? (Sp	ecify Ves or N	USI	14. Race - Ameri	can Indian	
9	after dea or Itams niner mi	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				nic Origin? (Sp Mexican, Puerto	Rican, etc.)		Black, White		
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 ahow Itaul Evannar must be notified a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2	ZNo S	pecify:			Specify: Bla	ck	
15-("natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual kind of work	Occupation done during	n ng most of work	in g	16b. Ki	ind of Business/Ir	ndustry	
2121	within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Gar	17 Ta Ti	netirea)			Gas	11/19/10/	10.	
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, than a	e C	17. Father's Name (First, Middle, Last)			11-110	18.	Mother's Name	e (First, Middle	e, Maiden	Sumame)		
/lar	wild by Menta	To Be	Edward Johnson				K	latie T	ucker				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow any injury or other traumatic event, the Medical Enumber must be notified at ances.		19a. Informant's Name/Relationship (Ty						The second second		r Town, State, Zij		
	1 and 1ealth am 27 ther t		NriSta lucker - H	010101	6639			ale Ave			mo a		
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr		1 Burial 2 □ Cremation 3 □ R			sition (Name natory or oth	er place)		Date		ocation - City or To		
i	permit. Pag Department Important: any injury c		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lie	Wes		. Name and	ery Address of		5,2005	bal	timore,	mo	
B	permi Depa Impo any is		Vary 1 h		Ga	alo W			Forth	Itan O	lass Boulto	mn 212	29
			23a. Part 1 Enter the disease, or complishook or heart failure. List only or	cations that caused the death,	Do not ent	er the mode	of dying, su	uch as cardiac	or respiratory a	arrest,	V.33 DIG 12	Approximate Interval Between	
	Physician	- 9	Immediate Cause (Final disease or condition	Stabu	٥٠٠	0 6	Ch	est				Onset and Deat	
1	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):			-5 (2.9		
		<u>-</u>	Sequentially list conditions,	Due to (or as a consequer	nce off-								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Little underlying Cause (Disease or injury that initiated events	240 (0) (0) 43 4 00((304))	100 01).								
ó	exection and and rial-tra	Еха	resulting in death) Last	Due to (or as a consequer	nce of):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	icai											
Ö	leath certific attending pl	Physician/Med	IF FEMALE:							_			
Вох	attenc for us	ian/	in the past 12 months?	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3□	Ectopic preg				2	23d. Date of delive Month	ery Day Year	
o.	the de y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	m 5L	Other (spec	л у)					,	
Q	res that the de sign e d by the a l be detached t	by Pt	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cau	se given in	Part I.	23e. Did 1	tobacco u	se contribute to the	ne cause of death	?
rds	w require been sig should b	ed b						<u> </u>	1 🗆	Yes 2	No 3□ Prob	ably 4 Unkn	own
Records,	ne faw re has be ge 2 sho	piet							24a. Was			psy findings avail	
=		Completed							A perfo	ormed?	death?	mpletion of cause 2□ No	OI .
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			0.1	Place of Death					
of	Phys r this ral di	: To	XXYes 2 No	1 Impatient 2 EH	VOutpatient Bb. Time of				ne 5 Resi 28d. Describe		Other (Specify	, at sce	ne
ion	Attanding F r death. actor: After by the funer	atior	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	М	Injury at Work? 1 ☐ Yes	2 X No	Suhi	e T	Stable	0-0	
Division	Attandi er death. ractor: A by the fu	Certification:	3 Suicide 6 Could not be determined	28 . Place of Injury - At home	e, farm, stre	et, factory, c	ffice		28f. Locatio (Street and	Number or Rura	I Route Number,	_
Ö	tal or rs afte al Dir	Cerl		building, etc. (Specify)	STRI	ECT			City or To	wn, state)	nousta	Aug	
	To tha Hospital or Attanding Phwithin 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 X Medical Examin	ician: To the best of my knowle er: On the basis of examination	dge, death	occurred at	the time, d	ate and place, a	and due to the	cause(s)	and manner as st	ated.	
	thin 2 the of the	Med	29b. Signature and title of certifier	and manner stated.			icense nur		C 10		signed (Month,		
	⊬ ≱ ⊢ 8		1/8 Islen				.C.M.				29, 200		
K	1	10	30. Name and address of person who con	impleted cause of death (Item 23	Ba) (Type, F					-			
L	1		J. Gron Lock	mpleted cause of death (Item 23				Baltim	ore, Ma	aryla	and 21201	1	
	Sta		31. Date filed (Month, Day, Year)	32 Restrar's Signature	y A	(arti)							
	Registr	ar	MAY 0 9 20	105 Janes 1	1								

			1- State of Maryland	/ Depa		alth and M	lental Hyg	•	5 15538
П	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Martha Anna Vey				2. Date of Deat Month May 4	2005 Yea	3. Time of Death 5:20a M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Carroll Lutheran Village		4b. City, Town, or Lo		nay 4	4c. County of De	eath
	Funeral Director		5. Social Security Number 215-05-1941 0	birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 13	Year) 9. E 1915 M	Birthplace (State or Foreign Country) D
	e Maryland a-f show	ctor	10a. State 10b. County 10c. City, To	own or Lo minst					10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Dire	10e. Street and Number 200 St. Luke Circle		10f. Zip Code 21158			0g. Citizen of What USA	Country?
980	4 within 72 hours after death with the Maryland Jione. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W Specify: W	
Maryland 21215-0036	a filed within 72 ho I Hygiene. other then "natur: rent, The Wedleal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual Occupation kind of work done duri DO NOT use retired) nemaker	on ing most of work	ing	16b. Kind of Busine	ss/industry
yland;	be filed ital Hyg of othe event,	To Be C	17. Father's Name (First, Middle, Last) Ferdinand Elgert		18		ta Reicl	Maiden Sumame) nner	
	ges 1 and 2 should to f Health and Men if item 27 is marke or other treumatic		T . 1 D 1 /1 1. \		g Address (Street and artz Rd., S				, Zip Code)
Baltimore,	Pant		20a. Method of Disposition 1 🛣 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	of Dispo etery, cren Viev	sition (Name of natory or other place) v Memorial			20c. Location - City Sykesville	
Balt	permit. Pag Depertment Importent: any injury o		21. Signature of Funeral Service Licensee Paige Haight Herbert	Ρ.	Name and Address of O. Box 195	5 Sykesv	ille, Mo	1 21784	& Chapel
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Description in the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence.	ce of):	neumo	rung			Approximate Interval Between Onset and Death
90,	te be executed ysicien and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence of the control o	ce of):	hergus	sedu	· Beer	destro	lul
P.O. Box 68760,	death certificate e attending phy: id for use as the	Physician/Medica	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d		Ectopic pregnancy Other (specify)			23d. Date of c	lelivery Day Year
Ś	sigr d be	by	Part II. Other significant conditions contributing to death but not resulting to death but not resulti	g in the ur	iderlying cause given i	in Part I.	23e. Did tob	_	to the cause of death? Probably 4 □Unknown
al Record	The law ete has b page 2 si	Completed	Spord Seeniss.				24a. Was ar autops perform 1 Yes 2	y prior t	
	ing Physic	ation; To Be		Outpatien b. Time of Injury	Other: 28c. Injury at Work?		me 5 Reside	nce 6 □Other (Sp w injury occurred	pecify)
Division	i di fie	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	, farm, stre	eet, factory, office	:	28f. Location (Str City or Town		Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ige, death and/or in	ocurred at the time, estigation, in my opini	date and place, a ion, death occurre	and due to the ca ed at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier		29c. License no		29	ed. Date signed (Mo	nth, Day, Year)
- 1	X		30. Name and address of person who completed eause of death (Item 23:	a) (Type, I	1)37a	dat		May 40	1 2US7
1	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatura	ma	, 2 horse	Alrene	12018	est, we	Misturba
	Registr		MAY 0 9 2005 > Reserve	K	hout &				

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ORIGINAL

			Pleas	se Type or Prin		partment of I					
			1 - For State Registrar	Otate of Wil		ertificate of		Wichtan	Reg. No.	UUD	15539
F	Physici		Decedent's Name (First, Middle KATHERINE A.					2. Date of D Month MAY			
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Dea			County of Dea	7
			UNION MEMORIAL				MORE CIT	Y		N/A	
	uneral rector		220-48-2253	6. Sex 7. Ag 1 ☐ M 23€ F	e (In yrs. last birthd 57 Yrs	Months Days			irth (ay, Year) 1947	9. Bi MA	nthplace (State or Foreign ountry) RYLAND
land	MO TE		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
Mary	P-f sh	tor	MD BALTI	MORE	PARKVIL	LE					1 ☐ Yes 2 ☐XNo
ith the	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What C	ountry?
aath w	s 23a	erall	8925 F WALTHAN	WOODS ROAD	Surviva II S	212		/CifV		JSA	
ter de	ltam mer n	Funeral	11. Marital Status 1 (XNever Married 2 ☐ Married	Armed Forces?		Was Decedent of I If Yes, specify Cub		orto Rican, etc.)	10-	14. Race - Am Black, Whi	
U Z I Z I S I S I S I S I S I S I S I S I	Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, I'm Medical Evertimes must be neithed at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No			3		WHITE
in 72	hadic Andic	Completed	15. Decedent (Specify only highes	t grade completed)	(G	cedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of w	orking	16b. Ki	ind of Business	Mindustry
d with	arthe.	Com	Elementary/Secondary (0-12)	3 YEARS		URSE			HOS	SPITAL	
ba file	d othe	Be	17. Father's Name (First, Middle, L	•				ame (First, Middl	e, Maiden	Sumame)	
al yla should l	narka natic	2	CLEMENT J. VIC					EIMBACH			
d 2 sh th and	7 is n traun		19a. Informant's Name/Relationsh CLEMENT J. VICK			ailing Address (Street					Zip Code) , MD 21234
F tan	tem 2		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla		Date Date	-	cation - City or	
Page:	nt: if		1 ☐ Burial 2 🛣 Cremation 1 ☐ Donation 5 ☐ Other (Sp.			REMATORY,	· · · · · · · · · · · · · · · · · · ·	6/2005	CATO	ONSVILL	E, MD
Dallillor Dermit: Pages Department of	Important: if item 27 is any injury or other tra once.		21. Signature of Euneral Service L	icensee							HOME, P.A.
1 8ă	F # 9		12			8521 LOCH				MD 2	1286
Phys	sician		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	only one cause on each lin	ne.	enter the mode of dyi		ac or respiratory	arrest,		Approximate Interval Between Onset and Death
/Me	edical		disease or condition resulting in death)	w	a consequence of):		7(17)				1 days
Exa	miner	_	Sequentially list conditions,			CLATIC	N				
pel	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i	Due to (or as	a consequence of):						
ехест	an and rial-tra		that initiated events resulting in death) Last	C. Due to (or as	a consequence of):						
ate be ex	hysicia he bu	Icai		d							
certifica	ding pl	Physician/Med	IF FEMALE:	23a Hung gutaama	of organization						
Batho	attend For us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		2	23d. Date of de Month	livery Day Year
j eg	by the	hysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown							
DIVISION OF YILD TO WE HOSPITED TO THE HOSPITE OF THE HOSPITE OF THE PROPERTY OF THE HOSPITE OF	i signed by the attending physician and Id be detachad for use as the burial-transit	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.				o the cause of death?
W req	as baen si 2 should l	ompieted						24a. Wa		24b. Were a	utopsy findings available completion of cause of
The t	certificate has rector, page 2	mo						auto perl	omed2 2 No	death?	completion of cause of
cien:	ertifica actor.	BeC	25. Was case referred to medical examiner?					eath (Check only			
hyei	this c	-T	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		IBIT 3LJ DOA		Home 5 Res			icify)
ding	After	tion	Natural 5 Pending		Year) Zob. Tille	y Wo	rk?]Yes 2∐No	28d. Describe	now injury	y occurred	
Atten or deal	ector; After this certificate haby the funeral director, page	Certification:	3 Suicide 6 Could n	ot be 200 Place of Init	ury - At home, farm,	street, factory, office		28f. Location	(Street and	d Number or R	ural Route Number,
tel or	ei Dir	Cert	- Indinide	building, etc	J. (Opecny)			City of 10	wn, State,		
To the Hospitei or Attendi	To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physician: To the best of examiner: On the basis of and manner sta	examination and/or	eath occurred at the till investigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
To the within	To th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Mont	th, Day, Year)
اہم	à.) W	MO		AC 2	43894	6613	MAY	,04,	2005
5	1		30. Name and address of person v								
V	Ch		31. Date filed (Month, Day, Year)	3 Registra	201 E	AST UN	NEECIL	1 BKN	17,6	BALTIN	IORE MD 2121
	Sta Registr	-	MAY 0 9 2	2005 Separe	J. J.	parti					

			State of M	aryland / Dep				gione	
			1 - State Of IVI		ertificate of L		_	2005	15510
		-	Hegistrar 1. Decedent's Name (First, Middle, Last)		ortificate of t	Death	2. Date of De	Reg. No.	3. Time of Death
	Physic		Morry weedon				Month	Pay 2005	14:25PM
	/Medi		4a. Facility Name (If not institution, give street and number,		4b. City. Town, or	r Location of Death	Civity	4c. County of Deat	h
	Examir	ner	North Arundel Hospit	-	Gleni		l	Anne F	lahawal
1	Funeral			ge (In yrs. last birthda)	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		hplace (State or Foreign ountry)
	Director		218.28.5862	71 Yrs.	Months Days	Hours Min.	SEPT 1	4, 1933	MD
	P .		Usual Residence of Decedent	140 00 #					
	arylae	-	10a. State 10b. County	10c. City, Town or	Location				10d. fnside City Limits
	the Marylar 28a-f show	Director	MD ANNE ARUNDEL	GLEN BUR			I		1 Yes 2 No
	or death with the Maryla tems 23a or 28a-f shor	D	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Co	untry?
>	sath w	ral	232 MARGATE DR. 11 Marital Status 12. Was Decedent	Everin II S 12	2106		noifu Voc or No	USA 14. Race - Ame	nican Indian
>	after dea	Į,	11. Marital Status 1 Never Married 12. Was Decedent Armed Forces 1 Never Married 1 Yes 2 Y	2 900	 Was Decedent of H iff Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, White	
3 8	or af	by	3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 ☐ No XX	Specify:		Specify:	HITE
	Z1Z15-UU36 Nd within 72 hours after death with the Maryland glene. et than "naturel", or Items 23a or 28a-f show the Medical Exacultive trust be notified at	ted	15. Decedent's Education	16a. Dec	cedent's Usuaf Occup	pation		16b. Kind of Business/	
	within 7 with 7 sne.	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life	ve kind of work done of DO NOT use retired	during most of work d)	ing		
0	AT Z IT	Con	10		HOMEMAKER			OWN HOME	
27	d officer	Be Completed by Funeral	17. Father's Name (First, Middle, Last)					, Maiden Sumame)	
0	aryian should be nd Mental marked c	2	ALLEN WITORT				LYN HOB		
Weedo	- G 00 =	10	19a. Informant's Name/Relationship (Type, Print) GORDON P. WEEDON, SR HU					er, City or Town, State, 2 , MD 21060	Tip Code)
\geq	s 1 and 2 the alth item 27 l		20a. Method of Disposition		position (Name of		Date	20c. Location - City or	Town, State
	Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	namatani a	EM CROWNS	VILLE 5.10	0.2005	CROWNSVILL	
3	Balti permit. Departm Importa any inju		21. Sign	7	22. Name and Addres	ss of Facility	P.A.		
	n gozad	20	K GREGORY KINK MO	11/2 4	26 CRATN F	HWY SW CLI	EN BIIRN	IE, MD21061	
			23a. Part1. Enter the disease or complications that cause shock, a heart failure. List only one cause on each	d the death. Do not e line.	enter the mode of dyin	ng, such as cardiac i	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	rotory	taiwr	e			
	/Medical Examiner		Due to (fr a	a consequence ou:	. 0				
		in line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consequence of):	164			6	
W	ned insit	in in	cause. Enter Underlying Cause (Disease or injury that initiated events	tatic N	Ion Smo	119911	Conc	e Chung	
`.	(60, s be executed sician and burial-transit	Examiner		s a consequence of):	VO/101/10	- I CUIT	CO 1C		
ì	- 0	cal							
	Box 68 leath certificat attending phy for use as th							477	
	BOX 68 eath certifica attending ph for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		3 □Ectopic pregnancy	v		23d. Date of del	
	o deal	sicis	1 Yes 2 No		5 ☐ Other (specify)			Month	Day Year
	that the de red by the a	Physician/Med	9 Onknown			- i- D i	00 - Did		- M
	dS, ires the signer	þ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	POSP		tobacco use contribute to Yes 2 ☐ No 3 ☐ Pr	robably 4 Unknown
	COrd w requir been si should I	eted	Cittoral Cionica	- noc he	Jr 14 015			2-3375	. i Be u
	Hec e law has b	Completed			<u> </u>		24a. Was	psy prior to death?	utopsy findings available completion of cause of
	al F						1 ☐ Yes	2 No 1 ☐ Yes	2 □ No
	of Vital Records, Physicien: The law requires t r this certificate has been signe yral director, page 2 should be o	o Be	25. Was case referred to medicaf examiner?		int of pos Oth	26. Place of Deat			
	Of Phys	⊢	1 Yes 2 2 No Nospital 1 Minpat 27. Manner of Death 28a. Date of In (Month, D.) 1 Natural 5 Pending		IGHT 3 DOA	4 Nursing Ho		idence 6 Other (Spe how injury occurred	city)
(1)	on C Iding P Ith. : After 1	tlor	1 Natural 5 Pending (Month, C	ay Year) Injur		rk? Yes 2 🗆 No			
M):	Division or Attending after death. Director: Afte	ifica	3 Suicide 6 Could not be 28e. Place of le	niury - At home, farm,	street, factory, office			Street and Number or Ri	ural Route Number,
	Div	Certification;	4 Notificial Building, 6	itc."(Specify)			City of 10	wn, State)	
	Division of To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only (Ch	of examination and/or	eath occurred at the tir investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time.	cause(s) and manner as date and place, and due	stated.
	o the ithin 2 o the omplel	Med	one) and manner s 29b. Signature and title of certifier	sia (0 0.	29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
	⊢≯⊢ŏ	1	Mario Quiro)	DO	103274	14	Mars 4	2005
	M		30. Name and address of person who completed cause of	death (Item 23a) (Tyr	ge, Print)	110 0		11	
			301 Hospital Drive	Wen !	rine	H1) 2	1061	MARIAGAV	IRA MD
	As .	tate		trans Signature	South :				
	Regis	trar	MAY 0 9 2005	Eve St	HORAL				

			For State Registrar		Marylan	d / Depa <i>Cer</i>	rtment of H	ealth a Death	and M	F	Reg. No.	15	15541
	Physicia	an	Decedent's Name (First, Middle,	Last)		_	ZANER			MAY 5,	300E	Year	3. Time of Death 2:30 A M
	/Medic	al	GENE 4a. Facility Name (If not institution,	nive street and numb			4b. City, Town, or	Location o	f Death	MAT 3,	4c. County	of Death	2:30 A W
	Examin	er	ASBURY METHODI				40. Olly, 10mi, 01			BURG	40. County		TGOMERY
Ī	Funeral Director				Age (In yrs. I	ast birthday) O Yrs.	If Under 1 Year Months Days	If Under:		8. Date of Birti (Month, Day JUL 24	, 1924		place (State or Foreign ntry) NY
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Aaryla F shored at	ŏ	,	UFF0LK	700.00.		POINT						1 ☐ Yes 2 👿 No
	28e-	rect	10e. Street and Number	OTTOLK		KOCK	10f. Zip Code				10g. Citizen of V	What Cou	ntry?
	h with	Funeral Director	4 WOODBRIDGE C	OURT				1177	'8				USA
	ems ?	ner	11. Marital Status	12. Was Decede		S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - Ameri k, White	can Indian,
36	or it	by Fu	1 Never Married 2 X Marrie	ed 1 Tes 2	X No		1 ☐ Yes 2 🌠 No	Specify:		, , , , ,	Specify		WHITE
5-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene naturel; or flems 23a or 28e-f show ant, the Medical Exam. In finish be notified a	ed b	3 Widowed 4 Divorced	Year or Date	es:	16a Dece	ient's Usual Occupa	ation			16b. Kind of B	ısiness/Ir	ndustry
<u></u>	n na	plet	(Specify only highest	arada completed)	015.1	(Give	kind of work done of DO NOT use retired,	lurina mosi	t of work	ing	TOB. Talla of Di	30111033411	idudity
2121	d with giene er the	Completed	Elementary/Secondary (0-12)	5+ College (1-4	or 5+)	TEACI	HER				EDUCATI	ON	
D	m = 0 =	Be (17. Father's Name (First, Middle, L	ast)							Maiden Suman	10)	0011511
Maryland	should be nd Mental marked o	10	KOLMAN			ZANE			NNIE				COHEN
a N	s 1 and 2 should by Health and Men Item 27 is marke other traumatic.		19a. Informant's Name/Relationsh RICHARD ZANER				ng Address <i>(Str</i> eet a RITAN COU				•		o Code)
တ်	theal		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place	1		Date	20c. Location -		own, State
Ê	Pages nert of nnt: If Ib iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate	-	AT CEMETE	' 1	5/05	5/2005	EAST FA	RMIN	GDALE, NY
altimore,	permit. Pages Department of Importent: If It any Injury or o		21. Signature of the Street of L	•	,		. Name and Addres				SON & BR		
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E			23a. Part1. Enter the disease, or o shock, or heart failure. List of	intrione callee on ear	h line								Approximate Interval Between
	Physician		Immediate dause (Final disease or ondition resulting in death)	- Meta	star	Tet.	rensite	mil	Ce	icen	enson	in	Anset and Death
	/Medical Examiner		rooding in dealtry	Due to (or	as a consequ	uence of):							,
		er	Sequentially list conditions, any, leading to misclate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or	as a consequ	ranca of):							
	cuted nd ransit	Examiner	that initiated events	C									
, 0	tate be executed thy sicien and the burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):							
8760	The law requires that the death certificate be executed tie has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	dical	,	d									
× 6	leath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregna	incv					23d Da	te of deliv	env
Вох	atten d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birt 4 ☐ Pregnar	h 2 ∏Fetal ntattime ofde	Ideath 3	Ectopic pregnancy Other (specify)					nth	Day Year
P.O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknow	m								
	res tha igned be del	by P	Part II. Other significant condition				nderlying cause give				/		he cause of death?
Records,	w require been si should?	ted	Anemaj	enioni							res 2. ☑No	3 Pro	bably 4 Unknown
ec	has by	Completed	Tyansa	guino	us.	2000	rocuta	ne	un	autop	sv .	prior to co	opsy findings available empletion of cause of
			quoliela.	Dignik	rd y	usqu	rla				2 No	death? 1 🔲 Yes	2 No
Z.	sicien: Th certificate irector, pag) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	vationt 2	ER/Outpatier	Othe			h (Check only o	<i>ne)</i> dence 6 □Oth	(С	4.1
o	Attending Physicien: The or death. ector: After this certificate hiby the funeral director, page by the funeral director, page	n; To	27. Manner of Death	28a. Date of	Injury	28b. Time o	28c. Injury	at			now injury occur		ry)
<u>o</u>	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Day Year)	Injury	World 1□	Yes 2	No				
Division of Vital	f or Attence after death Director:	ertification;	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of	f Injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office			28f. Location (S City or Tox		er or Rur	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	O							- 1				
	To the Hospitel within 24 hours a To the Funeral completely filled	edical		Physician: To the be exeminer: On the bas and manne	is of examina								
	o the	Me	29b. Signature and title of certifier			<i>*</i>	29c. License				29d. Date signe		
)	r s r ö		V. Paker	Beixil	har	us	10-	411	5		May	5,0	2005
i.	1		30. Name and address of person v	who completed cause	of death (Item	23a) (Type,	Print) 201 R	USS	844	AVER	MES	6	
V)						6-417	HER	58	CIRE, N	14 20	079	/
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9		gistrar's Signa	iture	de la						

Robert W. Applefeld Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-2729 State of Maryland / Department of Health and Mental Hygiene AKG 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death April 18, 2005 **Physician** 4:54 P M Robert Wayne Applefeld /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena 7952 Shady Grove Way Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Months Director Maryland 218-62-4719 Usual Residence of Decedent 1957 May 6, the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County iam 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7952 Shady Grove Way 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after No. If Yes, Give Year or Dates: 1 Never Married 2 Married 1974 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 Widowed 4 Divorced 1975 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) 12 Chemical Engineer Northrup Grumman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stanley Applefeld Joyce Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or othar traun 7952 Shady Grove Way Pasadona MD 21122
Date Doc Location - City or Town, State Patricia Applefeld Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositio 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 4/26/2005 Garrison, Maryland 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21 Signature of Funeral Service License 412 Washington Rd. Westminster, MD 21157 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONTACT GUNSHOT MOUND disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: nse : 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1,504 es 2 \(\subseteq \) No 24a Was an certificate has autopsy performed? 1 Z Yes 2□No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 2 1 X Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6X2Other (Specify) at SCENE 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending SUBJECT SHOT JELF 4/18/02 EDUA investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide PASADEN 7952 RESIDENCE SHADY GROVE WAY, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

WIL 154

> State Registrar

RUBIO MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

29b. Signature and title of certifier

aue to

32. Reastrar's Signature

111 Penn Street

OCME

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

April 19, 2005

		State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	lental Hygier	2005 5513
		Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Phys. /Me	ician dical	Jimmy Lee Allen	04 19	
Exan	niner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	
Directo		416-76-4618 19M 20F 51 Yrs. Months Days Hours Min.	Month, Day, Yea	53 A/a.
land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mary Heat	ţ	VA Accomack Nelsonia		1 Tes 2 No
ith the Marylar or 28a-f show	Olrec	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?
ath waste	Funeral Director	30/23 Metompkin Rd 23414	ψ_{i}	rited States
fter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc.
1215-0036 within 72 hours after death with the Maryland one. nne. ha Pretural; or Itema 23a or 28a-f show ha Neddeal Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify:		Specify: /3/K
15-C	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) [If DO NOT use retired]	ing 16b.	Kind of Business/Industry
212. I within iene. The M	dwo	Elementary/Secondary (0-12) College (1-4or 5+) A R Pen ter	1	Louses
/land 2 uld be filed Mental Hygi	BeC		e (First, Middle, Maid	en Sumame)
yla:	2	ressie Masshall Collis	٩	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mandal Hyghens Important: If it fem 21 a marked other than "netural", or Itema 23a or 28e-1 show any injury or other traumatic event, the Madical Exam. Set must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Elize Allen (wife) 3013 Matheway	al Route Number, City	y or Town, State, Zip Code)
re, N s 1 and f Health item 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or Town, State
Pages nent of I		12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	14/05P	Askeley 1/A
Baltimore, permit. Pages 1 ar pepartment of Hea important: If item: any injury or other	ouce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	H Meter	FUNCALITYONE
ш аова	a	22 Part For the disease or complications that equal the death De secretary to the death De secre	Pel A	CCOMAC VA 27301
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Approximate Interval Between Onset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	0-	lyear
Examine		Sequentially list conditions b.		
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
sxecut n and al-tran	xan	that initiated events resulting in death) Last Due to (or as a consequence of):		
8760, cate be executed physician and the burial-transit	dical E	d		
4618 ox 687 ox edificate anding physicuse as the 1	Medi	IF FEMALE:		
76 - 46 .O. Box 6 the death certific by the attending p	by Physician/Me	23b. Was decedent pregnant in the past 13 months? 1 Live birth 2 Fetel death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O. I that the de ed by the a detached t	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)9 Unknown		,
S, P. 6 s that the es that the igned by be detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
416 cords, requires been sign			1 ☐ Yes	2 3 Probably 4 Unknown
Hecords, P The taw requires that the has been signed b age 2 should be detailed.	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			performed 1 ☐ Yes 2 ☐	
	o Be	examiner?	h (Check only one)	6 □Other (Specify)
After this funeral di	n: To	27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in	
	Certification:	2 Accident investigation M 1 Yes 2 No		
Division Attents after death	rtif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
The Mospital or Attention To the Hospital or Attention Within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	o(s) and manner as stated.
the Ho nin 24 h the Fu	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
To the within 2 To the complete	Σ	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
		1 1 m.s. 93069.	A	1.1 22, 2005
J 111		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Temes MARTIN M. D. 145 E. Carroll 3 31. Date filed (Month, Day, Year) APR 2 6 2005	54 5	1:600- MN
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		7,
Reg	istrar	APR Z 6 2003 Johnson J. Marie		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of M	arylan	•	ment of F ficate of		mentai Hyt	giene Reg. No. 🔿 👸	10 pm	1 277 200 1 4
	_	1. Decedent's Nem	e (First, Middle	, Last)					2. Date of Dee		Year	3. Time of Death
Physiciai /Medica		BERT	'HA			AUS'	rin .		APRTI.	•	005	11:20 PM
Examine	-	4a Fecility Neme (/	f not institution	, give street end number,)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
				NURSING HOM				BOWI		PRINCE		
Funeral Director	- 1	5. Social Security N 220-22-66		6. Sex 7. Ag			f Under 1 Year Months Deys	If Under 24 Hrs Hours Min.		, Year)	9. Birthpla Counti NORTH	ace (State or Foreign ry) CAROLINA
	- 1-	Usuel Residence of		, ,	_				SONE TO	1712		
arylan show	- 1	10a. State	10b. County		10c. Cit	ty, Town or Locat	ion				10	d. Inside City Limits 1 X Yes 2 □ No
the Marylar 28a-f show notified at	2	MD		E GEORGE'S	MI	TCHELLVI						
with th	5	10e. Street end Nur		OTTOE			10f. Zip Code 2072	0		10g. Citizen of V U.S.A.		y?
eath w		907 MILI	TLONDOC	12. Was Decedent	Ever in U	IS 13 Wa			Specify Yes or No-		e - America	n Indian.
re, Maryland 21215-0020 s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	2	1 ☐ Never Marri		Armed Forces	?		es, specify Cub Yes 2 X No	an, Mexican, Puèr Specify:	Specify Yes or No- to Rican, etc.)	Specify	k, White, e	tc.
15-0020 72 hours aff	Completed	(Spec	15. Decedent	's Education t grede completed)		(Give kin	t's Usual Occup d of work done	during most of wo	rking	16b. Kind of Bu	siness/Ind	ıstry
vithin within the Me	Ē	Elementary/Seco		College (1-4or	5+)		NOT use retire					
filled v Hygie of the rt.	3	8th 17. Fether's Neme		Lasti		JANITOR	TAL SUP		me (First, Middle,		IVATE	
Maryland 21215-0020 d2 should be filed within 72 hours aft th and Mental Pyglene. The marked other than 'natural', or traumatic event, the Medical Event	10 De	ROBERT		RADSHAW				ILEY	DAR		-,	
Aaryla 2 should and Men 1s marke sumetic		19a. Informant's Na							urel Route Numbe			
Te, M	-	PAULETT 20a. Method of Disp		N/Daughter-	20b. F	Place of Dispositi	on (Name of		CHELLV LL Date	LE, MAK 20c. Location -		
Baltimore, Ma permit. Pages 1 and 2.0 Department of Health at Important: If them 27 is any Injury or other treu			Cremation	3 □Removal from State)	cemetery, cremat HURCH CE			4/27/05		•	Carolina
Balti permit. Departm Importa any Inju	1	21. Signature of Fu	J				ame and Addre		J. B. JEN			
Depa Depa Impo			ADA	100		747	4 LANDO		LANDOVE			
Physician	1	23a. Part I. Enter ti shock, or hea	ne dis se, l'ailure. List	complications that cause only one cause on each I	d the leat ine.	th. Do not enter t	he mode of dyir	ng, such as cardia	c or respiratory ar	rest,	;	Approximate Interval Between Onset and Death
/Medical Examiner		Immediate Cause (disease or condition resulting in death)		e Cardi	ac_Dy	sarryth	mia					
		resulting in dealin)			,	or as a conseque	· ·				i i	
nsit ted				b. Coro		Artery		e			1	
D, executand n and ial-tra	Examiner	Sequentially list co if eny, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, imediate		Due to (d	or es a conseque	nce or):				1	
68760, ificate be executed g physician and as the burial-transit	BOICE	Cause (Disease or that initiated events	injury	c	Due to (c	or as e consequer	nce of):					
		resulting in death) I	_ast		,		,				i	
Box sath cert attendin for use	rnysicianyn		-	d			-				1	_
e dead the at the at the at the	312	Part II. Other signif	icant conditio	ns contributing to death I	out not res	ulting in the unde	erlying cause giv	ren in Part I.	23b. Did t	obecco uee cor	tribute to	the cause of death?
C 273		Dem	entia						101	res 2™ No	3 Prob	abiy 4 □ Unknown
Records, he law requires the has been signe age 2 should be to	200								24a. Wes			e autopsy findings
w require s been si	Completed								репо	med?	com of d	ilable prior to pletion of cause eath?
The la ate ha page 2									101	es XINo	1 🗆	Yes 2X No
Vital sician: The certificate lirector, pa		25. Was case refer examiner?	red to medical					26. Place of De	ath (Check only o	ne)		
Of Vita Physician: this certific ral director,	2	1 ☐ Yes 2]					3□ DOA Oth	440 Nursing I	Home 5 ☐ Resid			1
ng Pl	5	 Menner of Death Natural 	5 Pendin	28a. Date of Inj (Month, De	ury by Year)	28b. Time of Injury	28c. Injui Wo		28d. Describe h	ow injury occurr	ed	
Vision Attending or death. ector: After by the fune	200	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	ot be	ium. At h	ome, farm, street		Yes 2□No	28f Location /9	Street and Numb	er or Rurel	Route Number
Division call or Attending Paragraphs at Director. Attentied in by the funers		4 Homicide	determi	building, e			, lactory, office		City or Tow	n, State)	BI OI HUIGI	rioute rumoei,
Hospi 24 hou Funer Stely fill	Palical	29a. Certifier (Check only one)	1 Certifyin 2 Medicai I	g Physician: To the best Examiner: On the basis of end manner s	of exemina	owledge, death or ation end/or inves	ccurred at the tir tigation, in my c	ne, date and place pinion, death occ	e, and due to the ourred at the time, o	ceuse(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)
To the vithin 2 To the comple		29b. Signature and	title of certifier				29c. Licens		1	29d. Date signed	(Month, D	-
		1	3D1	0/0	2!	4	1)	15664)	APRIL	27	2005
0 (3)	h	30. Neme end addr	ess of person	who completed cause of	death (Iter	n 23e) (Type, Pri	nt)					
		DPINDE					x Lane	# 124 Box	wie, Mary	yland	20715	,
State	-	31. Date filed (Mon	th, Dey, Year)	32. Regist	rar's Signa	ature						

DHMH 16 Rev 6/95

			1 _ For	State of	Maryland		artment of H		Mental Hyg	jiene		
			Registrar 1. Decedent's Name (First, Middle, La	ad)		Cer	uncate of L	Jealli	2. Date of Dea	eg. No.	05-	15515
	Physicia	an		HENRY	DX	RKLE	7		Month APR 2	Day	Year	13. Time of Death
	/Medic		PAUL 4a Facility Name (If not institution, give			KKT1E)	4b. City, Town, or	Landing of Dani			inty of Deatl	12:37 A M
	Examin	er			1		•		uı			
	Francis		NATIONAL NAVAL 5. Social Security Number 6.5		7, Age (In yrs. las	t birthdav)	If Under 1 Year	HESDA If Under 24 Hrs		1	ONTGOM 9. Birth	hplace (State or Foreign
	Funeral Director	i		M 2□F	88		Months Days	Hours Min	May 18,	Year)	Co	untry)
			Usual Residence of Decedent						110) 10)			
	nylan how		10a. State 10b. County		10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	e Ma Sa-f s	cto	Virginia Fairfa	ζ	McLea	n						1 ☐ Yes 2XQNo
	ith th	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen	of What Co	untry?
	ath w	40	6916 Southridge D				22101			USA		
	er de Items	Funerai	11. Marital Status	Armed Fo		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Race - Amei Black, White	
36	or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes If Yes, Giv	e 1943 ₂ t	0	1 ☐ Yes 2 🛛 No	Specify:		Spe	ecify:	White
21215-0036	72 hours after death with the Maryland natural, or Itema 23s or 28s-f show areal Examiner must be notified at	edt	15. Decedent's E			16a. Deced	ient's Usual Occupa	ation		16b Kind o	of Business/I	Industry
15	in 72 n "na	piet	(Specify only highest gr	ade completed)		(Give	kind of work done of OO NOT use retired,	during most of wo	orking	100.11.10	1 20011000	industry.
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1		Offic	er -Capta	ain		U.S.	Navy	
PL	e filed al Hygie other vent, II	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sun	name)	
<u> a</u>	should be nd Mental nmarked o	10	Eddie Patterson	Barkley				Lula Bel	1 Tolber	t		
Maryland	and s.m.		19a. Informant's Name/Relationship	*			g Address (Street a					
	Health Health tem 27 i		Paul A. Barkley/	on	act Di-		Boston Ave	enue, la				
0	ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from	State cerr	netery, crer	sition (Name of natory or other place		Date		on - City or 1	
Baltimore,	tant:		*4 Donation 5 Other (Speci		Arli		n National					Virginia
Bal	permit. Pages Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Lice	nsee		22	MONEY &	KING FU	NERAL HO	ME, I	NC.	
			23a Part Foresthe disease or con	nlications that o	ausod the death	Do not ent			ve., Vien		a. 221	80 Approximate
			23a. Part1. Enver the disease, or com shock, of heart failure. List only Immediate Cause (Final						ic or respiratory arr	est,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a			L LUNG CAI	NCER				
	Examiner			Due to (or as a consequer	nce of):						
	۹.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequer	nce of):						
J	s be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	exec an an	Exa	resulting in death) Last	Due to (or as a consequer	nce of):						
58760,	cate be executed physician and the burial-transit	dicai		d								
9		Wed	IF FEMALE:									
Вох	death certiff e attending id for use as	an/I	23b. Was decedent pregnant in the past 12 months?		come of pregnance irth 2 🗌 Fetal de		Ectopic pregnancy			23d.	Date of deli	ivery Day Year
0.	the a	Physician/Me	1 Yes 2 No	4□Pregn 9□Unkno	ant at time of deat own	th 5 [Other (specify)				WORKE	Day Tour
a	that the de ned by the a detached t	Ph	Part II. Other significant conditions	contributing to de	eath hut not resulti	na in the u	nderlying cause give	an in Part I	23e. Did to	bacco use o	contribute to	the cause of death?
ds,	sigr sigr d be	1 by	Tarris other signmount containons	sommodung to de	out i out i ot i oouti	ng in the di	idenying cause give	311 H 1 1 G.T.(1.	1 □ Y			obably 4 Unknown
Ö	w requ	etec							11	- 5004		
Record	has has	Completed							24a. Was a autop: perfor	sy	prior to c death?	topsy findings available completion of cause of
	(0)			1					1 Yes	No No		2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	anationt 205	2/Outration	t 3 DOA Othe	200	ath (Check only or		O45 (O	- Y .)
		7; To	1 Yes 2 No	28a. Date	of Injury 2	8b. Time of			Home 5 Resid			ciry)
ion	ft A i	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		h, Day Year)	Injury		<br Yes 2 □ No				
Division	after death Director: in by the	iffic	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow		ımber or Ru	ral Route Number,
Ö	tal or A	Certification;		Danda	ig, dia. (opeany)				Only of You	, olalo,		
	Hospital 4 hours a Funeral I	edical	29a. Certifier 1 Tertifying P	hysician: To the	best of my knowle	edge, death	occurred at the time vestigation, in my op	ne, date and plac	e, and due to the c	ause(s) and	l manner as	stated.
	the the	Medi	one)	and mani	ner stated.							
	To To To To To To To To To To To To To T	<	29b. Signature and title of certifier		12/	JN	29c. License	number 201465 (esa. Datejsić	./ -	n, Day, Year)
•			200	Fa	1.05	- L!				417	18/07	
	20		30. Name and address of person who TODD R. LAROC		e of death (Item 2 MC USN		Print)		NAL NAVAL SDA MD 20			ENTER
	Sta	ite	31. Date filed (Month, Day Year)	32. R	egerar's Signatur			DETHES	DUA IMU ZU	007-30	200	
37	Registi		MAY, 0 S	1 a a a b	Value		met D					

			riease	State of Mary				•		•		
		•	1 - For State Registrar AMEND ITEM	•	•			•	Reg. No.	711115	15	546
			Decedent's Name (First, Middle, Last	#5_PER_INE	G843 5/2	3/05 JH		2. Date of De	aath		3. Time	of Death
	Physici		Charles Frederick	Radlay				May 1,	Day 200		3:05	р ^М
die.	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death		7	County of De		
			Pleasant View Nur	sing Home		Mt. Airy			Ca	rrol1		
*	Funeral		5 Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Yeer)	9. Bi	rthplace (State	or Foreign
	Director		557 -42-3584	7	0 Yrs.			Mar. 7	, 19	35 Was	hington	DC_
	land		Usuel Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation					10d. Inside	City Limits
	Mary 1 eh	ţo	Maryland Carroll	Mt	. Airy						1 ☐ Ye	s 2 No
	r 28a	Director	10e. Street and Number	1110		10f. Zip Code			10g. Citi	izen of What C	Country?	
	d within 72 hours after death with the Maryland piele. I the Medical Examinet must be notified at the Medical Examinet must be notified at	alD	4101 Old Baltimore	e National F	ike	21771			USA			
	ems erms	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	14. Race - Am Black, Wh		
36	or it		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2 🎇 No				Specify:		
8	hours tural'	Completed by	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	pation		16h Ki	Wh ind of Busines	ite	
15	in 72 n "nat	plet	(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retire	during most of wor	king	100.10	nd or busines	a modstry	
212	filed within I Hygiene. other then "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Mechan	ic			Auto	motive	Repair	
b	be filed ttal Hygic ed other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle				
<u> a</u>	2 should be and Mental is marked sumatic ev	0	Clifford Frederick	c Bailey			Edith Ki	nd				
Maryland 21215-0036	and and and and	11 18	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State,	Zip Code)	
	1 and 2 Health tem 27 i		Evelyn Comer, daug		5C Fo	al Court	Cockeys	ville,				
Baltimore,	Pages 1 ar tment of Hea tant: If item ; jury or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	nemoval mom State		sition (Name of matory or other place	ı			ocation - City o		
ţi	nit. Partmen cortant: injury		'4 □Donation 5 □ Other (Specify				ory 5/4/				, Mary	
Bal	permit. Departminements imports eny inju		21. Signature of Funeral Service Licen		M00000 1	OC E	ss of Facility Kee	ney and	Bas	ford Fu	ineral	
			23a. Part. Enter the disease, or comp shock, or heart failure. List only of				Church St			rick, N	Approxima	
			shock, or heart failure. List only of Immediate Cause (Final					. ,			Onset and	etween
	Pnysician /Medical		disease or condition resulting in death)	a. Respirato Due to (or as a co		re					Years	
	Examiner			Progressi							Years	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co							rears	
	nd rar sit	Exan iner	that initiated events	c								
,092	ite be execute ysicien and ne burial-tran		resulting in death) Last	Due to (or as a co	nsequence of):							
687	# × 6	dlcal	•	d								
9 ×	the death certifica y the attending ph iched for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy					23d. Date of de	olison	
Вох	of the last	clan	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	у] 1	Month	Day	Year
O.	by the a	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown								
۵,	£ 8 €	by PI	Part II. Other significant conditions co	ontributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute	to the cause of	death?
rds	w requires been sign should be	pa pa	Pneumonia, Seizure	s, Prior st	roke, Or	ganic Bra	ain	1 🗆	Yes 2	□No 3□F	Probably 4 🛚	Unknown
Records,	as bee	Completed	Syndrome, & Hyperi	ension				24a. Was		24b. Were a	autopsy findings completion of	s available
	The late happen	E						auto perfo 1 ☐ Yes	ormed? 2 🔼 No	death?	s 2 No	cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea					
of V	nys ldir	To	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Ott	ner: 4X Nursing H	ome 5 Res	idence	6 □Other (Sp	ecify)	
	ing Ph Viter th uneral	ü.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wo		28d. Describe	how injur	y occurred		
Sio	or Attending ifter death. Director: After in by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		***		Yes 2 □No	206 1	(0)			
Division	al or Attending PI s after death. Il Director: After ti ed in by the funera	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, office		City or To	Street an wn, State	d Number or F	Rural Route Nu	mber,
J	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1 Certifying Ph	ysicien: To the best of m	v knowledge deat	h occurred at the li	me date and place	and due to the	Called/e\	and manner	as stated	
	24 h 24 h e Fun etely	Medical	(Check only one)	iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and	place, and du	e to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and Ale of certifier	an 1/	0	29c. Licens	se number		29d. Dat	te signed (Mor	nth, Dey, Year)	
}	-		> hiterwis 9	ach Va	-00N	D06588	3	7	Mav 1	2005		
	1		30. Name and address of person who			*						
	1		Melvin Joel Kordon			polis Roa	d, Ellic	ott City	y, MI	2104	2	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pagistrar's	Signature	180						

				epartment of Health and N Certificate of Death		ne 2005	15547
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Julia F. Bethea	4.05.7	APRIL 3	100-0	4:01 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Geo	orana
	Funeral		Doctors Community Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		ace (State or Foreign
	Director		Usuel Residence of Decedent	rs. Months Days Hours Min.	Jan. 22.	1915 West	Virginia
	72 hours after death with the Maryland natural', or items 23e or 28e-f show jical Exaction from the rollified at	_	10a. State 10b. County 10c. City, Town			10	Od. Inside City Limits
	Ba-f s	Funeral Director	MD Prince Georges New C	arrolton			1⊠Yes 2□No
	with the or 2	ä	10e. Street and Number	10f. Zip Code 20784	10g.	. Citizen of What Coun USA	try?
	ns 23	era	7613 Riverdale Rd. #103 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America	an Indian.
9	or Iter	Fur	1 Never Married 2 Married 1 Yes 2 Amo		Rican, etc.)	Black, White, e	_
03	arall,	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: Blac	:K
21215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 160	b. Kind of Business/Ind	lustry
12	within the the the the the the the the the the	diuc	Elementary/Secondary (0-12) College (1-4or 5+) 8th.	Cook	U.	S. Soldier	s Home
d 2	Hygi other	Be C			ne (First, Middle, Mai	iden Sumame)	
/lan	vid be Menta rrked rtc ev	ToB	John Clay	Nannie	Parson		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, it a Medical Exaction from the notified at			Mailing Address (Street and Number or Rur	ral Route Number, C	ity or Town, State, Zip	Code)
	s 1 and 2 of Health item 27 l			13 Riverdale Rd. #10	3 New Car	rolton, Md	20784
altimore,	iges 1 or of F or ot		1 XBurial 2 Cremation 3 Removal from State	reek Cemetery 4-28-		c. Location - City or Too shington,	
買	permit. Pages to Department of Himportant: If ite any injury or ot once.		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility MA		AND 100 PM	
Ва	Departiment of the policy of t		D Marshall	4217 9th. St. N.W.	Washingto	on, D.C. 20	011
	Physician /Medical Examiner		23a. Pand Enter the disease, or complications that caused the death. Do not show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebro Vascu Due to (or as a consequence of the conditions)	lar Accident	or respiratory arrest		Approximate Interval Between Onset and Death Day S
,8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the condition of the condit				
.O. Box 6	The law requires that the death certifics are has been signed by the attending pt page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	10-0	23d. Date of deliver Month	ry Day Year
Records, P.	quires tha	Completed by P		the underlying cause given in Part I.		cco use contribute to the	
၀	e law requir has been si je 2 should	piet	Carolid Artery Stenous		24a. Was an autopsy	24b. Were autop	sy findings available
H.		mo	Diabetes Mellitis		performed	d? death?	npletion of cause of
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)		
of	d is	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou			e 6 Other (Specify)
UC UC	ding F	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 1 Pending (Month, Day Year)	ime of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa			et and Number or Rural	Route Number,
Ö	s after s after al Direction by in by	Cert	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (, death occurred at the time, date and place, 1/or investigation, in my opinion, death occur	and due to the caus	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To the To the To the Comp	Ĕ		29c. License number	29d.	. Date signed (Month, L	Day, Year)
)			PARAND ALAVIMO Parand Alawim	D0058275		4-21-05	
2	(20)		30. Name and address of person who completed cause of death (Item 23a) (PARANI) ALAVI, ND 8118 GCODLU		20706		
	Sta Registi		APR 2 6 2005	barle			

			For State Registrar	State of Maryland / Dep Ce	artment of Health an		jiene	1551.8
			Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death
	Physicia /Medic		RONALD	K. BYRD		April	15, 2005	2:00 Pm
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of D	eath	4c. County of Deat	
			2621 Shananda		Silver Spr		MONTG	OMERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday, 5 2 Yrs.	If Under 1 Year If Under 24 Months Days Hours N	lin. (Month, Day	(, Year) 9. Birt	hplace (State or Foreign
L	Director		Usual Residence of Decedent	32 Hs.		Feb.14	,1953 Wa	ash. DC
	dand ow		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Man a-1 sh	tor	MD Montgo	mery Sil	ver Spring			1 ☐ Yes 2 ☒ No
	h the	irec	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Co	ountry?
	23a d	Funeral Director	2621 Shananda	le Drive	20904		U.S.A	•
	r dea	nei	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ②【 No If Yes, Give	1 ☐ Yes 2 █No Specify:		Specify: Bla	ack
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28a-f show than "netural", or Itams 21a or 21fied at the Maryland Examiner must be notified at	edb	15. Decedent's Educ	Year or Dates:	ident's Usual Occupation		16b. Kind of Business/	Industry
5	n "ne	Completed	(Specify only highest grade	completed) (Give	kind of work done during most of DO NOT use retired)	working	TOD. THIS OF DUSTINOSS	madatty
212	d with	mo;	Elementary/Secondary (0-12)	College (1-4or 5+) 3 yrs Cen	tral Office T	ech	Verizo	on
b	al Hy I otha	Be C	17. Father's Name (First, Middle, Last)			Name (First, Middle,	,	
yla	Ment Ment arka atic	^C	Edgar Byrd			Sylvia Co		
Maryland	2 sh and ls m		19a. Informant's Name/Relationship (Typ		ing Address (Street and Number o			
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health, or Itams 23a or 28a-1 show itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event. The Marylical Examiner must be notified at		Tiffany Byrd (7 Ritchboro F		20c. Location - City or	
altimore,	perriit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		1 ☑Burial 2 ☐ Cremation 3 ☐ Re	Sinovariioni State // II	osition (Name of matory or other place)			
量	rtani njury	1	 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lie 		.coln Cem 4/ 2. Name and Address of Facility		Bladensbu	
ä	Dep Imp		Juga.		246 N . Washi			
	-		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not en	ter the mode of dying, such as car	diac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		E-mation			Onset and Death
	/Medical		resulting in death)	Myocardial In: Due to (or as a consequence of):	arction			
	Examiner		Sequentially list conditions b	Hypertension Due to (or as a consequence of):				10 yrs
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a consequence of):				
	and I-trans	Examlne	Cause (Disease or injury that initiated events resulting in death) Last	Diabeles Toe	e II			10 yrs
8760,	cate be executed physician and the burial-transit			0.500.500.500.500.550.800.6	Digongo			10 yrs
687	ficate physis the	edical	d	Coronary Arter	DISease			10 yrs
Box	death certifi e attending i d for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	¬ -		23d. Date of del	ivery
	death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify</i>)		Month	Day Year
P.0	that the death certific ed by the attending f detached for use as	Physiclan/M	9 Unknown	9□ Unknown				
	es be	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to	
orc	v requires been sign should be	ed				- 1UY	es 2□No 3□Pr	obably 4X Unknown
Records,	2 S S	Completed				24a. Was a autops	sy prior to o	topsy findings available completion of cause of
alF						perfor 1 ☐ Yes	med? death? 2xNo 1 ☐ Yes	2□ No
Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	ospital:	Other	Death (Check only or		
of		\vdash	1 ☐ Yes 2 🔀 No	28a. Date of Injury 28b. Time	of 28c. Injury at	-	ence 6 Other (Specow injury occurred	cify)
lon	변 문 물 글	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		. ,	
Division	Attan er deatl actor: by the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		treet and Number or Ru	iral Route Number,
Ö	tal or rs afte al Dir ed in	Cert	- Troffliolds	building, etc. (Specify)		City or Tow	n, State)	
	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor:	edical	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	th occurred at the time, date and p	lace, and due to the c	ause(s) and manner as	stated.
	the h	Med	one)	and manner stated.				
1	P. F. A		29b. Signature and title of certifier		29c. License number	4	29d. Date signed (Monti	
•	50		30 Name and address of	mpleted cause of death (Item 23a) (Type	D14404		April 21	
			Charles Frank		.Pnnt) O New Hampshi	re Ave	Silver S	20904 pring, MD
	Sta	ite	31. Date filed (Month, Day, Year)	20 Daniel Ciano				
Ę.	Regist	rar	APR 2 5 2005	Le Hegistrar's Signature	W.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 19, 2005 11:15 P ^M Edna M Burleigh April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctor's Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2X F 88 02/03/1917 Maryland 215-46-1156 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Prince George's Mitchellville 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10405 Lottsford Road Apt-211 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Specify: White 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hospital Operations Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Murdock Margaret Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B Burleigh - Husband 10450 Lottsford Rd Apt-211 Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 04/22/2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.) omes! lear 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Gram Negative Sepsis 4 Days Due to (or as a consequence of): Sequentially list conditions, if any, backing to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? 1 ☐ Yes 2 XNo Dementia 25. Was case referred to medical examiner?

Physician /Medical Examiner

Funeral

Director

r than "natural", or Itams 23a or 28a-f show The Mexical Examinar must be notified at

death

within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "n any injury or giber traumatic event, Te Media once.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as tha burial-transit the detached signed by been has certificate Be 은 : Aftar this funeral o

The law requires that the death certificate be executed

Box 68760

o

Records, P.

Division of Vital

Physician:

To the Hospital or Attanding

death.

within 24 hours aftar d

To the Funeral Direct
completely filled in by

27. Manner of Death Certification: 29a Certifier

þ Completed

1 ☐ Yes 2 X No

1 X Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

Director:

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H Yablonowitz, MD 7404 Executive Pl Suite-502 Lanham, MD 20706 31. Date filed (Month, Day, Year)

2 5 2005

5 Pending investigation

6 ☐ Could not be

determined

32 Registrar's Signature

Hospital: 1 X Inpatient 2 ☐ EP/Outpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

3 DOA

28c. Injury at Work?

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D25079

29c. License number

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

04/22/2005

29d. Date signed (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		For State Registrar	State of	Marylar		artmen tificate			and M	ental Hyg	giene Reg. No.	005	an and support	5550
Physicia		1. Decedent's Name (First, Middle, I Thomas F. A. B	,	•_						2. Date of Dea Month Apr.	19,	2005	r	Time of Death 7:30 a M
/Medic		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of	of Death		1	County of De		7.30 a
LXaiiiiii		754 Trenton Av				Se	everi	na Pa	rk			Anne A		el
Funeral				7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth	h (Year)	9. B	irthplace (State or Foreign
Director		157–18–0675	10 3 M 2□F	78	Yrs.	MOTITIES	Days	nours	Will.	Mar. Ti	, 19:	27	Journay)	NJ
and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation		-					10d. In	side City Limits
e Maryl 8e-f sho	ctor	MD Anne	Arundel				Sev	verna	Par!	k				□Yes 2ÃNo
h with the	ai Dire	10e. Street and Number 754 Trenton Ave	enue			10f. Zip		146			10g. Citiz	on of What C	Country?	
paritimities in the state of the source of t	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XVidowed 4 Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2 🔂 No	1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe), Puerto f	cify Yes or No- Rican, etc.)		4. Race - Ал Black, Wh		
within 72 hor ene. than "natura the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		-4or 5+)	life. L	dent's Usua kind of wor DO NOT us	k done d e retired)	luring mosi)		ng	Fam	d of Busines ily-Ow iness		
Id be filed ental Hygi ked other ic event, II	To Be Co	17. Father's Name (First, Middle, La James D. Brown,	st)					18. Mothe	er's Name	(First, Middle, ustin				
2 should and Men is marke	H	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	er or Rura.	l Route Numbe	r, City or	Town, State,	, Zip Code)
C, Z		Thomas Brown, 20a. Method of Disposition	Jr/Son	20b	2806	LOVE	Poi	int R	oad,	Steven	svil	le, MD	21	666
mit. Pages partment of I portent; if it y Injury or o		1 ☐ Burial 2 ②Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State	cemetery, cren etro Cr	natory or of	ther place	9)	Apr. 20	21, 005		timore		iaio
permit. Departrimporte any inju		21. Signature of Funeral Service Lie	a Z	le	B2 49	Name and Prrance	Addres O &	s of Facility Sons itchi	P.A	A. Seve	rna l	Park F	unera Mo	al Home 21146
Physician /Medical Examiner		23a. 1. Enter the List on lock, or the List on limediate Cause (F and disease or condition resulting in death)	_a L	aused the dea ach line.	can	er the mode	e of drying			r respiratory ari			Appr	roximate val Between et and Death
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lasse Cause) that initiated events resulting in death) Last	c	or as a consec										
The country, I. C. DOA 00 100, The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of o	aldeath 3	Ectopic pro					23	d. Date of do	elivery Day	Year
w requires that shear signed be should be detailed.	by P	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to				se of death?
The law reate has bee	Completed									24a. Was a autops perior	sy	24b. Were a prior to death?	completio	ndings available on of cause of
sicien: Th	Be (25. Was case referred to medical examiner?	Hanettel				7			(Check only of	he)			
ling Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of (Mont		28b. Time of Injury		3c. Injury Work	r: 4 □ Nui at ? ′es 2 □ I	2	ne Seside 8d. escribe h		Other (Sp	ecify)	
i or Attendir after death. I Director: Al	ertification:	3 Suicide 6 Could not determine	be 28e. Place	of Injury - At h	nome, farm, stre ify)	eet, factory	, office		2	8f. Location (S City or Town		Number or F	Rural Rout	te Number,
To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical Ex one)		usis of examination ner stated.	ation and/or inv	estigation,	in my op	inion, deat	th occurre	d at the time, d	late and p	lace, and du	ue to the c	
To the within To the comp	Me	29b. Signature and title of certifier	(1,0)	1/	ui)	29c	License	number	,	2	9d. Date	signed (Mor	oth, Day, 1	Year)
		30. Na and address of person wh	o completed caus	e of death (Ite	m 23a) (Type,	Print)	Das	nd s	#2-	× 4.	-	2/1	111	2/6/1
Star Registra		29b. Signature and title of certifier Hanne 30. Na and address of person wh Jeanne Wer 31. Date filed (Month, Day, Year) APR 2 2	2005	egistrar's Sign	ature	34	,			- (1111)	riap	1113,1		2.701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year PAULINE EVA BURRIS 500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Year If Under 4 Hrs. Regional Nedical Center NILONICO Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 89 221-24-0005 Yrs. Director NOV.3,1915 DELAWARE Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23e or 28a-f showing the Medical Examiner must be notified at **₫DELAWARE** SUSSEX SEAFORD 1 ☐ Yes 2 TvNo Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7 BIG MILL BRANCH ROAD 19973 AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BLOXOM DAUGHERTY DELLA BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 in Department of Health ar Importent; If item 27 is any injury or other treusonce. CARL A. HORNE - EXECUTOR 32435 HORNE LANE LAUREL, DELAWARE 19956 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ODB TELETOWS other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/05 SEAFORD, DELAWARE * 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 21. Signature al Service License WATSUNGYATES FUNERAL HOME, INC. Part1. Enter the disease shock, or heart failur. SEAFORD, DELAWARE 19973 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. e, or complications the List only one cause Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) fscv D **Physician** /Medical Due to (or as a consequence of). Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Examiner Due to (or as a consequence of): buriai-transit DEMENT that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ™onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed death 2 🗆 No 1 🗌 Yes 2 2 No 1 TYes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide

The law requires that the death certificate be executed Division of Vital Hospital or Attending Physiclen:

the Maryland

filed within 72 hours after death

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ent: If item 27 is marked other than '

Maryland 21215-0036

28a-f show

within 24 hours after death To the Funerel Director: Medicai 000 State

this

After

death.

29b. Signature and title of certifier Babulal Dan.M.D.

29a, Certifier

(Check only

M.D

29c. License number

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

057952

4/17/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sales bury MD 106 Milford ST # 5043.

31. Date filed (Month, Day, Year)

APR 2 5 2005

Registrar

DHMH 17 Rev 1/2001

State

Registrar

APR 2 6 2005

PHYLLIS

BRADFORD,

			For Stata Registrar	State o	f Maryland		artment rtificate			and M	lental Hy	giene	201)5	15554
(2)	Physici		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	eath Day	,	Year	3. Time of Death
	/Medic			ROWN							APRIL	16,	200)5	4:39A. ^M
	Examir	ner	4a. Facility Name (If not institution,		,				Location of	f Death				of Death	
			PRINCE GEORGE S 5. Social Security Number 6		7. Age (In yrs. la	et hirthday		EVER		24 Hrs	O Data of B				ORGE * S
	Funeral Director		577-42-3209	1 ½ M 2 □ F	74	Yrs.			Hours	Min.	8. Date of Bi (Month, D				place (State or Foreign ntry)
			Usual Residence of Decedent						1		June 9	, 19	30_1	AUGU	STA, GA
	larylan show	_	10a. State 10b. County		10c. City,	Town or L	ocation							1	10d. Inside City Limits
	Ba-f s	ç	D.C			W	ASHIN	GTON							1 TyYes 2 □ No
	or 2	를	10e. Street and Number				10f. Zip					10g. Citi	izen of V	Vhat Coul	ntry?
	ath w	ā	648 Morton St.,	_		,		200						Stat	
	er de item	nu.	11, Marital Status 1 Never Married 2 Married	Armed Fo		13.	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Orig n, Mexican	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	can Indian, etc.
36	rs aft	by Funerai Director	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	/e		1 ☐ Yes 2	₽ □xNo	Specify:				Specify		-1-
21215-0036	n 72 hours after death with the Maryland "natural", or iteme 23s or 28s-f show edical Experiment be retilind a	Completed	15. Decedent's	Education		16a. Dece	dent's Usua	l Occupa	ation			16b. Ki	ind of Bu	Bla siness/In	
215	within 7: ene. than "n	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	1-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired	du <i>ring most</i> I)	of work	ing				,
21	filed withit Hygiene. other than ent, ILE M	Į.	8th	00090 (,		Tr	uck	Drive	r			Tr	ucki	ng
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	First, Middle	, Maiden			
Val	should band Ments marked	10	Unknown						Lei	1a 7	homas				
Maryland	2 shd and is m		19a. Informant's Name/Relationship				-				A Route Numb				Code)
	l and Heelith om 27 her t		Vernita Brown	/ Daugnte							sh., D.				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural;, any highry or other traumatic event, Ite Medical Erap once.		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from	Oluto		osition (Nam matory or ot								own, State
詳	it. Partimer rtmer rtant njury		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie 	A	Ches		e Cre		_			Belts			
Ba	Depermine Depermine Impo		21. Signature du diferat Service Lit		AST A	110	2. Name and		1		N.E.				uary Inc.
			23a. Part . Enter the disease, or on shirth, or heart failure. List or	mp ications that c	aused the leath.								• , Д		Approximate
	Dharistan		shock, or heart failure. List or Immediate Cause (Final	/					3,		,	,		1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	TRATORY		UKE	_							
8	Examiner				STATIC N		IA RYNG	ΕΔΤ.	CANCE	TP.					
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	or as a conseque		211(11(0)		OZZZYOZ	*I.C				-	
	cuted nd ransi	Examiner	that initiated events	с.											
0,	e exe ian a urial-t		resulting in death) Last	Due to (or as a conseque	ence of):									
8760,	certificate be executed nding physician and use as the burial-transit	Physician/Medical		d		_								-	
9	eath certifics attending pl for use as t	Med	IF FEMALE:	00- 16											
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	come of pregnand wirth 2 Detail of lant at time of dea	death 3	Ectopic pre					2	23d. Date Mor	e of delive oth	ery Day Year
o.	The law requires that the death tte has been signed by the atter vage 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		10 JL	Other (spe	эспу)							
σ.	res that tigned by	y Ph	Part II. Other significant condition	s contributing to de	eath but not result	ting in the u	inderlying ca	iuse give	en in Part I.		23e. Did	tobacco u	ise contr	ibute to th	he cause of death?
ds	puires n sign	d by									1 🗆	Yes 2	S No	3 🗌 Prob	abiy 4 Unknown
Records,	w requir been si should I	Completed							•		24a. Was	 : an	24b. V	Vere auto	psy findings available
Re	sician: The law certificate has b irector, page 2 s	mo									auto perfe	psy ormed?	p	rior to co leath?	mpletion of cause of
Vital		Be C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes			☐ Yes	2 No
\leq	> 0 0	To B	examiner? 1 □ Yes 2 ॡ No	Hospital: 1⊠I	npatient 2 E	R/Outpaties	nt 3 DO	A Othe			ne 5 ☐ Resi		5 □Othe	er (Specifi	(v)
Jo u	ding Ph n. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (of Injury 2 th, Day Year)	28b. Time o	f 28	Bc. Injury Work			28d. Describe				,,
Sio	Attending r death. ector: After by the fune	atic	2 Accident investigation	ion		,,	М		Yes 2□N	olo					
Division	l or Attendatter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	ad 286. Place	of Injury - At hom ng, etc. (Specify)	ne, farm, st	reet, factory,	office		1	28f. Location (City or To			er or Rura	I Route Number,
	urs af urs af urai D														
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the ba	asis of examination	ledge, deat on and/or in	h occurred a vestigation,	it the tim in my op	ie, date and pinion, deat	d place, a h occurr	and due to the ed at the time,	cause(s) date and	and mai place, a	nner as st ind due to	tated. the cause(s)
	ithin 2 the mple	Mec	29b. Signature and title of certifier	and mani	ner stated.		29c.	License	number			29d. Date	e signed	(Month	Day, Year)
	F 3 F 8		V ant	Maria				27		7		211	1100	100	,,
n	(1)		30. Name and address of person wh	o completed raus	e of death (Item 1	23a) (Type	1	41		/		7/	13	/ 42	
1	0		OPHNELL CUMBERBA	•			Centr	а1 Δ	Ve -	T.ar	ndover,	Ма	207	785	
	Sta	ite	31. Date filed (Month, Day, Year)		egistrar's Signatu	re		A. A.	.,.,	பவ	و ۲۵۷۷ دیم	riu •	_40/	رن	
	Registi	ar	APR 2 5 20	טע כטו	we &	Son	W.								
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ORIGINAL

			For State Registrar	State of N	Maryland / Dej Co	partment of ertificate o		and Mental H	ygiene	n s	The long long long
	•	<u>j</u> io	Decedent's Name (First, Middle, I	Last)				2. Date of D	Death	Year	3. Time of Death
	Physicia /Medic	al -	Laura Birklar					April	24, 2005)	3:30p M
	Examin	er	4a. Facility Name (If not institution, g		•	4b. City, Town	or Location of lerick	of Death	4c. County	y of Death lerick	-
	Euparal		Frederick Men 5. Social Security Number 6		Age (In yrs. last birthda			24 Hrs. 8. Date of E	Birth		lace (State or Foreign
	Funeral Director		212-38-7670	1□M 2∏F	85 Yrs.	Months Day	s Hours	Min. Sept.	6, 1919	Virg	inia
	pul &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	Maryla f aho	ō	Maryland Freder	ick	Frederi					ľ	1 ☐ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number			10f. Zip Code)		10g. Citizen of	What Cour	ntry?
	23e o	ai D	7407 Willow Roa	d			21702		U.S	.A.	
ထ	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "natural", or tems 23e or 28e-f ahow avent, the Medical Ever if writinal by rutified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force	nt Ever in U.S. 1; \$?] No	3. Was Decedent of If Yes, specify Co		gin? (Specify Yes or to, Puerto Rican, etc.)		ce - Americ ick, White,	
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates					Specia	Wh	ite
15-(n 72 h "natu adica	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Gi	cedent's Usual Occ ve kind of work don b. DO NOT use ret	ne durina mos	t of working	16b. Kind of B	Business/Ind	dustry
712	iene.	omp	Elementary/Secondary (0-12)	College (1-40 5+	r 5+)	Teacher	,00)		Publi	c Sch	ools
ğ	be filec tal Hyg d other avent,	Bec	17. Father's Name (First, Middle, La	•				er's Name (First, Midd			
ylaı	2 should be filed withir and Mental Hygiene. Is marked other than eumatic avent, Ite M	To	James Wilbur Cr				Ne1	lie Grace	Copenhav	er	
Maryland 21215-0036	ges 1 and 2 should it of Health and Men if item 27 is marke or other treumatic		John Cutshall (C			-		er or Rural Route Num sboro, Mar	•		Code)
	is 1 and 2 of Health a item 27 ls other trei		20a. Method of Disposition	410817017	20b. Place of Dis	position (Name of rematory or other p		Date	20c. Location		own, State
ÛE.	Page nent o int: If		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		(0)	dge Ceme	· 1	4/27/05	Thurmon	t, Ma	ryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Fund ral Surviv	To De a	/ R	22. Name and Add	dress of Facility	Y & SON FU			
	₹0 = 9		23a. Parti. Enter the disease, or or	RUZY /	/ 6	15 EAST I	MAIN SI	TREET, THU	RMONT, M	D 217	88 Approximate
	Physician /Medical Examiner		23a. Pafrit Enter the disease, of coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_ a	as a consequence of):	15 ch	f M	Source of Temperature,	e (Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	ai Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequence of):						
687	ficate g phys ts the	edicai		d		-					
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify)				ate of delive onth	ery Day Year
S, P	res that igned to be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in the	e underlying cause	given in Part I				ne cause of death?
ord	w requir been si should	eted	- Klmyn 109	1 17/12	f 14 12 1 9	4			Yes 2 5 No		ably 4 Unknown
Vital Records,		Completed	1h/Jn(1	y-(ho	CY102 L	en (en	119	24a. W au pe 1 🗆 Yes	rformed?	Were auto prior to cor death? 1 Tes	psy findings available mpletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death (Check onl			
of	ling I. After une	ition: To	1 Yes 2 No 27. Manner of Death Tatural 5 Pending Investigation Pending Pendin	28a. Date of la (Month,		e of 28c. Ir	ijury at Vork? □ Yes 2 □		esidence 6 🗍 Ot e how injury occu		y)
Division	el or Attendi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Flace UI	Injury - At home, farm, etc. (Specily)	street, factory, office	Ce Ce	28f. Location City or	(Street and Num Town, State)	ber or Rura	il Route Number,
	To the Hospitel or a within 24 hours after To the Funeral Direction completely filled in E	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the be kaminer: On the basis and manner	st of my knowledge, de of examination and/or stated.	eath occurred at the r investigation, in m	time, date ar y opinion, dea	nd place, and due to thath occurred at the time	ne cause(s) and m	nanner as s , and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		^	29c. Lice	ense number		29d. Date sign	ed (Month,	Day, Year)
)			1 (Mari	> 1/4	m/ in		6428		1 4/2	5/1)
_	9		30. Name and a res of person w Casper E. Cline	, MD 300	of death (Item 23a) (Type West 9th S	treet, Fr	ederio	k, Marylar	nd 21701	1	
**	Sta Regist		31. Date filed (Month, Day, Year) APR 2	5 2005 32. R	strar's Signature	frank .					

			For State Registrar	State of	Marylan		artmen rtificat					giene	C U U D	15556
	Dhysisi		1. Decedent's Name (First, Middle,	Last)		-					2. Date of De Month	ath Day	/ Year	3. Time of Death
	Physicia /Medic		EARLE DeWITT								April	25,	2005	8:45 P ^M
	Examin	er	4a. Facility Name (If not institution,		nber)				Location of	of Death		4c.	County of Dea	ath
	Funeral		12 St. Martin' 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Bir	th .	n/a 9. Bir	nthplace (State or Foreign
	Director		217-18-2775	1 M 2 □ F	87	Yrs.	Months	Days	Hours	Min.	March March	19,	1918 °	nthplace (State or Foreign ountry) Canada
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	ocation							10d, Inside City Limits
10	Maryll f sho	tor	Maryland	n/a		Baltim	ore							1 Des 2 No
3	h the	lrec	10e. Street and Number	,			10f. Zip					10g. Cit	izen of What C	ountry?
3	death with the Maryland ms 23a or 28a-f show rmst be ruitied at	ralD	12 St. Martins I	₹d.				2121					U	JSA
	er des Items rer m	Funeral Director	11. Marital Status	Armed For	dent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.))-	 Race - Am Black, Whi 	erican Indian, ite, etc.
336	Irs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes II Yes, Giv Year or Da	9		1 ☐ Yes	2 No	Specify:				Specify:	White
9-0	72 hou	Completed by	15. Decedent' (Specify only highest			16a. Dece	dent's Usua	l Occupa	ation	t of worki	22	16b. K	ind of Business	
215	ithin 7	nple	Elementary/Secondary (0-12)	College (1			kind of wor DO NOT us				ng			
12	iled w tygier thar th	Co	17. Father's Name (First, Middle, L	astl	+	Dire	ctor	ot D			(First, Middle,	-	raphic	Art
and	d be f ental h ced ol	To Be	Rhae Gurensey								Belle 1			
aryl	shoul ind Me ind Me ind mark	Ĕ	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a					r Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be ruitlied at once.		Carlyle Barton,	Jr./P.R.						, Su	ite 140	00,	Baltimo	ore, MD 21202
ore	ges 1 of He If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	olale	Place of Dispo emetery, crei					ate		ocation - City or	
ţ	t. Pag tment rtant: njury o		`4 ☐ Donation 5 ☐ Other (Sp	ecify)	Chr									lge, Maryland
Bal	permi Depa Impo any ir		21. Suprature of Funeral Service L	Icensee	1///0	00	Curra Curra	n-Br		L Fu	neral l	Ноте	, 2P643	
		1	23a. Part1 Enter the disease, or other shock, or healt lailure. List of	comble tions that ca	aused the deat	h. Do not ent	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,	21013	Approximate
	Physician		Immediate Cause (Final disease or condition	Inly onexcause on en	SMAZII (I		nein			tasta	/	Jeno	was 10	Interval Between Opset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a conseq		00/ 0	,,,,,	1110	10016	ary C.	4014	11-14	01 100
	Examiner	ų.	Sequentially list conditions,	b										
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dence oi):								
Ć.	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):								
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			d										
9	entifica ing ph e as th	by Physician/Medical	IF FEMALE:											
Вох	that the death certifica ed by the attending pt detached for use as t	lan/	23b. Was decedent pregnant in the past 12 months?		come of pregna irth 2□Feta ant at time ol d	I death 3[Ectopic pr						23d. Date of de Month	elivery Day Year
	it the de by the a	nyslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		eaui 5L	_ Other (sp	өспу)						
Division of Vital Records, P.O	res that signed b	y Pt	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	inderlying c	ause give	en in Part I		23e. Did t	obacco ı	ise contribute t	to the cause of death?
rds	w require been sig should b	ed b									1 🗆	Yes 2	3 0 3□P	robably 4 Unknown
900	e law requ has been je 2 shoul	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
- -		Соп									perfo	rmed? 2/2 No	death?	s 2□No
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar		(Check only o	one)		
of	Physic this sral di	To I	1 ☐ Yes 2 No 27. Manner of Death	1 🗆 1	npatient 2 of Injury h, Day Year)	ER/Outpatier 28b. Time o		8c. Injury	4 140	rsing Hor	ne Pesi 28d. Describe		6 □Other (Spe v occurred	ecify)
ion	Attanding or death. actor: After by the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	,	h, Day Year)	Injury	М	Work				,	,	
<u>V</u>	of or Attandi after death. I Diractor: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place buildin	of Injury - At he	ome, larm, str	reet, factory	, office		- 1	28f. Location (Street an	d Number or F	lural Route Number,
	spital or Attanding Phous after death. naral Diractor: After the filled in by the funeral									<u> </u>				
	Ho Fur ely	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the examiner: On the ba	asis of examina	wledge, deat ition and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	id place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To tha Hos within 24 h To tha Fun completely	Med	29b. Signature and title of certifier	and manr			290	. License	number			29d. Da	te signed/(Mon	th, Day, Year)
	⊢ s ⊢ ŏ		> Gellem	Sychan	Mrs lor	7	1)334	100			041	26/201	25
			30. Name and address of person	o ompleted caus	e of death (Iten	п 23а) (Туре,	Print)					- / /	- 1,200	
-			<u>Iredell W. Ig</u>	lehart, M	.D., 63	01 Nor	th Ch	arle	s St	reet,	Suite	5,	Baltimo	ore, MD 21204
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7	2005	egistrar's Signa	iture	and a					,		•
			U1 1/ × (8 53 4 B 18 18 18 18	7.63	AND THE REAL PROPERTY.							

n •			State of Maryland / De 1- State Unpend Item 23a,27,28a-f per m Registrar	partment of Health and M 5 G843 5-11-05 tas ertificate of Death		
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Ted Carson Charles		2. Date of Deatl Month April	2/ 2005 2:39 P M
e O	* /Medic Examin		4a. Facility Name (If not institution, give street and number) 329 Horseshoe Road	4b. City, Town, or Location of Death Rising Sun	ipiti	4c. County of Death Cecil
300	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 228-66-5882 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, NOV 30,	Year) 9. Birthplace (State or Foreign Country) Virginia
	ith the Maryland or 28e-f show	ctor	Maryland Cecil Elkton			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
	ns 23e	Funeral	728 West Pulaski Highway 11. Marital Status 12. Was Decedent Ever in U.S. 1	21921 3. Was Decedent of Hispanic Origin? (Spe	acify Yes or No-	United States 14. Race - American Indian,
920	urs after d el', or Iten Examiner	Ď	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1967	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 A No Specify:	Rican, etc.)	Black, White, etc. Specify: White
3altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show may injury or other treumatic event, tre Modical Examinar must be notified at once.	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working. DO NOT use retired) Ssembler	ng	16b. Kind of Business/Industry Automobile Manufacturing
and 2	d be filed v ental Hygie ked other t c event, III	To Be Co	17. Father's Name (First, Middle, Last) James Adam Charles, Jr.	18. Mother's Name 01a Ne1		
any	should land Menis market	F		ailing Address (Street and Number or Rura		City or Town, State, Zip Code)
≥, ₹	and 2 lealth a m 27 fs			. Box 265, Elkton,		
nore	ages 1 nt of H t: If ite / or of		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gilpin.	sposition (Name of rematory or other place) Mayor 1 Park 2005	2,	20c. Location - City or Town, State
Baltin	permit. P. Departme Importent any injury once.					A.: ton, Maryland 21921
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		r respiratory arre	st, Approximate Interval Between Onset and Death
8760,	Examiner paying the purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
Вох б	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed to should be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 █Ūnknown
Vital Records, P.O.	The law requirate has been page 2 should	Completed			24a. Was an autopsy perform 1 X Yes 2	prior to completion of cause of
Division of Vita	Attending Physicien: The law requires that the death certific cleath. sctor: After this certificate has been signed by the attending reports the funeral director, page 2 should be detached for use as	ertification; To Be	25. Was case referred to medical examiner? 1\(\text{X Yes} \) 2 \(\text{No} \) 27. Manner of Death 1 \(\text{Natural} \) 5 \(\text{Pending} \) Pending 2 \(\text{Accident} \) Accident	e of 28c. Injury at 2		nce Mother (Specify) at scene
Divis	i Giri	O	3 ☐ Suicide 4 ☐ Homicide 6 ② Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) found in van			eet and Number of Gural Rouse Number Road State) 329 Horseshoe Road in, Maryland
	To the Hospitef within 24 hours a To the Funerel I	Medical	29a. Certifier (Check only one) One) Certifying Physician: To the best of my knowledge, did not not not not not not not not not not	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the vithin ?	Mec	29b. Signature and title of certifier	29c. License number	29	ld. Date signed (Month, Day, Year)
			Janha R. Mood See M. 30. Name and address of person who completed cause of death frem 23a)	O.C.M.E.		pril 28, 2005
jása			1663114 22017 (6) 1001	Penn Street, Balti	imore, M	aryland 21201
	Sta Regist	8	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	level !		

ity Name (If not institution, 16 Binyon Court Security Number	George 6. Sex XXXXM 2 F 7. George'S 12. Was Decedd Amed Forci 1 Yes 2 If Yes, Give Year or Date 2 George to Gollege (1-4) 4 College (1-4) Last) rge Cobleigh	Age (In yrs. I 62 10c. City For series? No es:	ast birthday) Yrs. 7, Town or Locort Wash S. 13. V	Ft. If Under Months cation ington 10f. Zip 20 Was Deced I Yes, spec	Town, or Washii Year Days Code 744 ent of Hisry Cubar In Occupa	Specify:	Death 4 Hrs. Min.	2. Date of Des Month April 24 8. Date of Birt (Mogth, Da) October city Yes or No-Rican, etc.)	Day 4c. (Pri 10g. Citiz US.	county of C nce Geo 42 Per 2en of What A	Death Drge's Birthplace (State County) DINSY I Vani	e City Limits
esidence of Decedent te 10b. County and Prince (eet and Number 6 Binyon Court tal Status Never Married 2 Marri Widowed 4 Divorced 15. Decedent (Specify only highes entary/Secondary (0-12) er's Name (First, Middle, I Arthur Geor ormant's Name/Relationst thia Cobleigh / thod of Disposition Burial 2 Marrian	George's 12. Was Decedd Armed Force 1 Yes 2 If Yes, Give Year or Date of grade completed) 4 College (1-4) Last) rge Cobleigh	62 10c. City For service of the content Ever in U.service of the	Yrs. 7. Town or Loort Wash S. 13. V	cation ington 10f. Zip 20 Was Deced f Yes, spec	Code 1744 ent of His ify Cubar	spanic Origin, Mexican, Specify:	Min.	(Month, Da) October	10g. Citiz US.	en of What A 4. Race - A Black, V	10d. Insid 1 🗀 ' t Country? American Indian	e City Limits
te 10b. County and Prince (eet and Number 6 Binyon Court tal Status Never Married 2 Marri Widowed 4 Divorced 15. Decedent (Specify only highes entary/Secondary (0-12) er's Name (First, Middle, I Arthur Geor ormant's Name/Relationst hia Cobleigh / thod of Disposition Burial 2 Marchanian	12. Was Decedd Armed Force 1	ent Ever in U.ses? Si No es:	ort Wash	10f. Zip 20 Nas Deced f Yes, spec I Yes 2 tent's Usua kind of wor	Code 1744 ent of His ify Cubar XXNo	Specify:	in? (Spe Puerto I		US.	A 4. Race - A Black, V	1 🗆 1	Yes XXI No
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er's Name (First, Middle, I Arthur Geor ormant's Name/Relationst thia Cobleigh / thod of Disposition Burial 2 Cremation	4 College (1-4 Last) rge Cobleigh		life. L	DO NOT us	k done di e retired)				16b. Kin	d of Busine	ess/industry	
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Other significant conditio	ns contributing to deat	th but not resu	Ilting in the ur	nderlying ca	use give	n in Part I.						
case referred to medical						00 81		autop: perfor 1 Yes	sy med? 2xxNo	prior death	to completion	gs available of cause of
niner? Yes 2 🙀 No ner of Death Natural 5 🗍 Pending	28a. Date of (Month,	Injury	ER/Outpatient 28b. Time of Injury		A Other	r: 4 □ Nurs at ?	sing Hon	ne 5√€ Resid	ence 6		Specify)	
	and 286. Place of	f Injury - At ho I, etc. <i>(Specity</i>	me, farm, stre	eet, factory,	office		2			Number or	Rural Route N	lumber,
ne) 2 Medical E	examiner: On the basi and manner	is of examinat	wledge, death ion and/or inv	estigation,	in my opi	inion, death	place, a occurre	d at the time, o	date and p	olace, and	due to the caus	
m. Po	witelf .	Staff of death (Men	pluga 23a) Type	L111-1	License		14				-	7)
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Place of Injury - At home, farm, street, factory, and manner stated. The pregnant investigation investigation and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of Injury - At home, farm, street, factory, and manner stated. Place of	Attention of the pregnant the past 12 months? Case referred to medical miner? Yes 2 No There is designed to medical miner? Yes 2 No Case referred to medical miners to make the past of miners to make the past of miners the	Att.: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cook, or heart failure. 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Due to (or as a consequence of): d. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (At Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, occ., or heart failure. List only one cause on each line. a. Metastatic Esopha eal Cancer or conditions and place to great the mode of dying, such as cardiac or respiratory arrest, or condition or conditions and print death) b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a co	At It. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, occording to mental title. List only one cause on each line. a. Metastatic Esopha eal Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): d. Due to (or as a consequence of): d. 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Pres 2 [No or Order of Death (Check only one) The residence of Ceath (Month, Day Year) All pregnant the underlying assegnment of Death (Check only one) The residence of Death (Check only one) The residence of Ceath (Month, Day Year) All pregnant to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 23c. Litury and the office of the cause(s) and manner stated. 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 24d. Was an autopsy performen? 12d. Certifying Physician: To the bests of my knowledge, death occurred at the time, date and place, and and manner stated. 23d. Date of plant (Park only one) 23d. Date of Death (Death only one) 23d. Date of Death (Check only one) 23d. Date of Death (Check only one) 24d. Was an autopsy perfor	### 22. Name and Address of Facility George P. Kalas Fruneral Home P.A. ### 6160 Oxon Hill Road Oxon Hill, Maryland 20745 ### 6160 Oxon Hill Road Oxon Hill, Maryland 20745 ### 6160 Oxon Hill Road Oxon Hill, Maryland 20745 ### Approximation of the cause on each line. ### Approximation oxon oxon oxon oxon oxon oxon oxon o

			For State Registrar	State of N	Maryland		rtment of I		and M	lental Hy	giene Reg. No	7111	5 15	550
Phy	sicia	'n	Decedent's Name (First, Middle, Las	Louis C	HOTTIN					2. Date of Do Month April	eath		3. Time of 2:40	
	ledic amine		4a. Facility Name (If not institution, give		•		4b. City, Town, o	or Location o		TIP I II		. County of De	ath	
. Fune		5	Montgomery Genera 5. Social Security Number 6. Security Number		Age (In yrs. la	**	if Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D Dec. 3	rth av, Year)	9. E	Sirthplace (State of Country) ennsylvar	-
Direc			193-03-1544 Usual Residence of Decedent 10a. State 10b. County			86 Yrs.	cation			Dec. 3	1, 1	910 F	10d. Inside Cit	
e Maryk	Milled a	Director	Maryland Montgome	ry			Spring						1 □ Yes	
h with th	at De no	al Dire	10e. Street and Number 3116 Adderley Cou	rt			10f. Zip Code	20906				izen of What ted Sta	,	
urs after deat	SKIP III ME I - M	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 XYes 2 If If Yes, Give Year or Dates	s?] No		Vas Decedent of I Yes, specify Cub		gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc. white	
Dallilliore, Infallylating Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 271s marked other than "neturel; or Items 23a or 28a-f show	the Mudical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retire	durina most	t of worki	ing		ind of Busine: Liquor	ss/Industry	
d be filed antal Hyg	c event,	Be	17. Father's Name (First, Middle, Last) Samuel Cho	ttiner						(First, Middle Le Spod		Sumame)	_	
nd 2 shoul alth and Me	r traumati	၉	19a. Informant's Name/Relationship (7) Esther Chottiner,	ype, Print)			g Address (Street Adderle						, Zip Code) 20906	
Pages 1 a ent of Hei nt: If item		ĺ	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Ce Ce	metery, cren	sition (Name of natory or other pla on Cemet			0ate 5/05		delphi	or Town, State	
Dallingi permit. Pages Department of Importent: If it	any inju		21. Signature Fun (al S vice) ic			To	Name and Addre	ss of Facility	^y ew F	uneral			20012	
	,		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each	line.	Do not ente		ng, such as	cardiac c			on, DC	20012 Approximate Interval Bety Onset and D	ween
Pnysic /Medi Exami	ical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	as a consequ	ence of):	PNE	PATH	-Y					
% ;		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ		INEX	MOTO	/4					
The law requires that the death certificate be executed the has been signed by the attending physician and	e burial-trans	dicai Examlner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequ	ence of):			• • • • • • • • • • • • • • • • • • • •		_			
OX OO h certifica anding ph	use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon			ICi					23d. Date of c	lelivery	
that the death certific ed by the attending p	iched for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant	at time of de		Ectopic pregnand Other <i>(specify)</i> _	у				Month	Day Y	'ear
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	director, page 2 sh	Completed	Of Warrant American							1 Yes	psy omed? 2D00	prior t death		ivailable luse of
_ × ×	al directo	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 No	Hospital:		ER/Outpatien	3 DOA	ner: 4 □ Nu	rsing Ho	me 5□Res	idence		pecify)	
5 0	by the fur eral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Dayi Year)	28b. Time of Injury		ryat rk?]Yes 2 □ t	No	28d. Describe			Rural Route Numb	her
DIV Ditel or A Urs after orel Direct	lled in b)		4 Homicide determined	building,	etc. (Specify,)				City or To	wn, State)		
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A	completely filled in	edical	(Check only 2 Medicel Examone)	ysician: To the be niner: On the basis and manner	st of my know of examinati stated.	viedge, death ion and/or inv	estigation, in my	me, date and opinion, deal	d place, a	and due to the ed at the time	date and) and manner d place, and d	as stated. ue to the cause(s)	
(0 X		Σ	29b. Signature and title of pertifier	Cos			29c. Licen:	S-SOL	745	5	29d. Da	te signed (Mo $4/2$ 4	f/2005	_
w · t	`		30. Name and address of person who	Zeugshir	f death (Item	23a) (Type,	Print) Gas	Biev 16	Par	W W	50	200	and FA	eP
Re	Sta gistr	100	31. Date filed (Month, Day, Year)	05 Section	strar's Signat	ure god	ule						as stated. ue to the cause(s) nth, Day, Year) f / ScS , MAPFA	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1- State
Registramend item #19a per inf g843 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year Julia C. Campbell 22 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22 John Adams Lane E1kton Ceci1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthplace (Month) | 9. Birthpl 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1□M 2√2F Yrs. 67 Director 161-28-4213 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "nsturel", or Itame 23a or 28a-f show treumetic event, the Medical Exeminar must be notified at Director 1 ☐ Yes 2 No PADelaware Aston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2975 Summit Circle 19014 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is merked other then "natural", or iter any injury or other traumatic event, the Medical Examinat 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ፩ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 12 Mortgage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hugh J. Gallagher Margaret M. Devitt ga Informant's Name/Relationship (Type, Print) PANTEL CAMPBELL/SON Panual Campbell/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danua 1 2975 Summit Circle, Aston, PA 19014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Ridley Park April 24,2005 White-Luttrell 21. Signature of Foregal Service Licensee Funeral 122 Momes Address of Facility Andrew G. Gee Funeral HOme 259 E. Main St., Elkton, 21921 23a. Part1. Enter the disease, or exemplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eas and disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) To the Hospitsi or Attending Ph within 24 hours after death. To the Funsrsi Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sin

32. Registrar's Signature

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W Kas

31. Date filed (Month, Day, Year)

APR 2 5 2005

		1	1 – For State Registrar	State of Man		artment of H			giene	005.1556	Mary 1100
			Decedent's Name (First, Middle, La	ist)				2. Date of De	ath Day	3. Time of Death	
	Physicia /Medic		Ray Kenneth Came	ron				April		005 4:00 PM	1
	Examin	er	4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, or	r Location of Dea	ath —	4c. Co	ounty of Death	
L			4057 Joseph Drive 5. Social Security Number 6.5		'n yrs. last birthday)	Eden If Under 1 Year	If Under 24 Hr	S R Data of Bird		omico	
н	Funeral Director			1 3 M 2 □ F	75 Yrs.	Months Days	Hours Mir		y, <i>Year)</i> Q2Q	9. Birthplace (State or Foreig Country) Virginia	"
			Usual Residence of Decedent					J/ ±J/ ±	<i></i>		
	hours after death with the Maryland lursi; or Items 23e or 28e-f show al Exarainer must be multiled at		10a. State 10b. County		0c. City, Town or Lo	cation				10d. Inside City Limits	
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	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Country?	
	s 23	erai	4057 Joseph Drive	12. Was Decedent Eve	arin IIS 13	21822	lispanic Origin?	Specify Yes or No	US.	Race - American Indian,	
	lter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	i	Was Decedent of H II Yes, specify Cuba		rto Rican, etc.)		Black, White, etc.	
21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene. Id other than "natural; or items 23s or 28s-f show event. Its Madical Examiner must be mailised at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2♣ No	Specify:		St	_{Decify:} White	
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7	within 72 ene. than "nai	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)				
2	filed will Hygien other th	S	17. Father's Name (First, Middle, Lasi	1)	Carpe	enter	18 Mother's N	ame (First, Middle,	Kenn	y Gillespie	
Maryland	od of	Be c	John Harrison Ca					ia Elono		·	
2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Ita M.	T _o	19a. Informant's Name/Relationship		19b. Mailie	ng Address (Street				own, State, Zip Code)	-
S	2 = 7 = 3		Barbara Cameron/v	wife	4057	Joseph Dr	rivo Ede	m.MD 218	22		
Baltimore,	of Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		Date	20c. Local	tion - City or Town, State	
Ĕ	ages ent of nt: if it ry or o		1 ☐ Burial 2 【 Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		Salisbury		1	2/05	Salis	sbury, MD	
a	permit. Depart Import any inj once.		21 Signature of Funeral Service Lice		22	2. Name and Addre	ss of Facility				
n —	2011		Marie #. OR	mysso,	CFSP 5	Ol Snow I	Hill Rd.	Salisbu	ry, M	onal Association D 21804	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the one cause on each line.	e death. Do not ent	er the mode of dyin	ng, such as cardi	ac or respiratory ar	rešt,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cardior	ngo palon						
	/Medical Examiner		Testing in dealing	Due to (or as a c	onsequence of):						
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	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	te be executed ysician and ie buriat-transit		resulting in death) Last	Due to (or as a c	onsequence of):						
1760,		ical		d .							
89	es that the death certifica igned by the attending ph be detached for use as tt	Med	IF FEMALE:								
8	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy	,		230	d. Date of delivery Month Day Year	
.O. Box	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne ol death 5	Other (specify)				,	
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Sp	uires sign ld be	d by						1 🗆 🕆	/es 2□	No 3 Probably 4 □Unknown	1
Ö	w require s been sig should b	lete				,		24a. Was	an 2	24b. Were autopsy findings available	8
He	The lav	Completed						autor perfo	rmed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
ta	i cian : Th certificate rector, pag	0	25. Was case referred to medical				26. Place of D	eath (Check only o		10.163 20.110	
>	nysician: nis certific I director,	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 Resid	ience 6	Other (Specify)	
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Vivision of	deal deal ctor: y the	rtification			- At home, farm, str Specify)	reet, factory, office		City or Tox	vii, State)		
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Division of	s Hospital or Attending P 24 hours after death. e Funeral Director: After tetely filled in by the funera		2 Accident 3 Suicide 4 Homicide investigation of determined	building, etc. (my knowledge, deat	h occurred at the tin		ce, and due to the	cause(s) an	nd manner as stated. ace, and due to the cause(s)	
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	Funeral Director		5. Social Security Number 578-52-7144	6. Sex 152 M 2□ F	7. Age (/	n yrs. last birthde Yrs.	y) If Under Months	1 Year Days	If Under 24 F Hours M	Irs. 8. Date of Bi in. (Month, D	irth ey, <i>Year)</i>		lace (State or Fore	ei g n
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	or 28e	Director	10e. Street end Number				10f. Zip				10g. Citizen of	What Coun	try?	
	ath wi	rai	4169 Southern				2074	43			USA			
020	be filed within 72 hours after death with the Manylend tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	If Vac Gi	orces? 2 1 No ve	or in U,S. 1:	B. Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		ice - America ack, White, e	etc.	
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Baltimore,			20e. Method of Disposition			20h. Place of Dis		ne of		Date	20c. Location			
ij	ortant: If its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other			Cedar H			•	4-27-05	Suitlar	nd, Md		
Bal	permit. Peges Depertment of important: If it any injury or once.		21. Signature of Funeral Service Many E. Lea	e Licensee Izman			22. Name and 111 Penn			Cedar Hill Suitland,		lome,Inc		
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that c st only one cause on e	aused the	death. Do not e	nter the mode	e of dying	g, such as card	iac or respiratory a	ırrest,	l	Approximate Interval Between Onset and Death	
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	anding r use	M/Jie		d	510	nary		revi	y -	Disea	se			
O. E	tha death cert y the attandin ached for use	Physician/M	Part II. Other significant condit	lons contributing to de	eath but no	ot resulting in the	underlying ca	use give	n in Part I.	23b. Did	tobacco use co	entribute to	the cause of dea	th?
Δ.	w requiras that tha death cerbeen signed by the attandin should be detached for use	2								1 🗆	Yes 2□ No	3 Probe	ably 4 Unkni	own
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1	0	-	30. Name end eddress of person	who completed agus	LU don't	(Item 22a)	Deint))4	321/		4/2	2/0	7	
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	Sta Registr	·C 3	31. Dete filed (Month, Day, Year APR 2 5	2005	egistrer's	Signature	we							

DHMH 16 Rev 6/95

		1- State of Maryland /		artment of H			giene Reg. No.	200	12700
Physicia /Medic		Decedent's Name (First, Middle, Last) Mary Gray Munroe Cobey				2. Date of Dea Month April	Day 20	2005	3. Time of Death) 19:40 P M
Examin	er	4a. Facility Name (If not institution, give street and number) 6910 Pineway		4b. City, Town, or Univers	sity Pa	rk		ince Ge	eorge's
Funeral Director		5. Social Security Number 213-42-6009 Usual Residence of Decedent 6. Sex 1 □ M 2X F 92 92	Yrs.	If Under 1 Year Months Days	Hours M	in (Month Day	1912	1 Co	hplace (State or Foreign untry) rida
Maryland a-1 show	tor	10a. State 10b. County 10c. City, To		cation cy Park					10d. Inside City Limits 1 1 1 Yes 2 □ No
with the 3a or 28	i Director	10e. Street and Number 6910 Pineway		10f. Zip Code 20782)		10g. Citize	of What Co	ountry?
Baltimore, Maryland 21213-UU36 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23s or 28s-1 show any injury or other traumatic event. It a Modical Exameter i just be coulded at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 \(\) Widowed 4 \(\) Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\) Yes 2 \(\) No If Yes, Give Year or Dates:	1		spanic Origin?	(Specify Yes or No- erto Rican, etc.)		I. Race - Ame Black, White pecify:	
Maryland 21215-UU36 d 2 should be filed within 72 hours at th and Mental Hygiene. It is marked other than "natural", or traumatic event. It e Medical Expire traumatic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired) emaker	ition uring most of v	working		of Business/	Industry
Iryland should be file ad Mental Hy marked othe matic event.	To Be C	17. Father's Name (First, Middle, Last) Mark Munroe 19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	ng Address (Street a	Mary F	lame (First, Middle, rances Gr Rural Route Numbe	ay		7in Codel
e, Ma 1 and 2 s Health an sm 27 is ther trau		Julia Gluck, Daughter	906 V	Vaynewood	Blvd.,	Alexandr	ia, '		La 22308
Saltimore, permit. Pages 1 ar Department of Hea mportant: if flem any injury or othe		'4 □Donation 5 □ Other (Specify) Rock	Cree	sition (Name of natory or other place of the Cemeter	ry 4/2	5/2005	Wash:	ington	, DC
Departiment of the policy of t		21. Signatura of Funeral Service Licensee				asch's Fu venue, Hy		A CONTRACTOR OF THE PARTY OF TH	
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Description shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Conjective Heart Structure and Conjective Heart Structure and Conjective Heart Structure.	art E		, such as card	liac or respiratory an	rest,		Approximate Interval Between Onset and Death 12 Months
Examiner	er	Sequentially list conditions b. Coronary Arte	ry Di	sease					10 Years
8760, sate be executed physician and the burial-transit	Examine	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or sequence or seque		sion					25 Years
68/60, ificate be ex g physician as the burial	edical	d <u>Peripheral Ar</u>	teria	al Disease	2				25 Years
HECONDS, P.O. BOX 68/60, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)			23	d. Date of deli Month	ivery Day Year
ecords, P. law requires that as been signed by	by	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause give	n in Part I.				the cause of death?
	e Completed						sy med? 2X No	prior to death?	topsy findings available completion of cause of
on of ling Phys ling Phys After this uneral di	To B		Outpatien Time of Injury	28c. Injury Work	r: 4 □ Nursing	Death (Check only of Home 5\(\) Resid 28d. Describe h	ence 6		city)
DIVISION Ital or Attending Its efter death. rai Director: Afte led in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow		Num <i>ber or R</i> u	ral Route Number,
To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled to the basis of examination and manner stated.	dge, death and/or inv	estigation, in my op	inion, death oc	ace, and due to the occurred at the time, o	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
To I To I	×.	29b. Signature and title of certifier		29c. License				signed (Month $1 22, 2$	
(10)		30. Name and address of person who completed cause of death (Item 23 William E. Battle, MD, 5530 Wisc		Print)					20815
Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2005							

Division or Attending death. Director: To the Hospital within 24 hours a To the Funerel D

Medicai State Registra

(Check only one) 29b. Signature and title of cert

6 XCould not be determined

Found in creek 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

29d. Date signed (Month, Day, Year) APRIL 3, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State) **2400 Chillum Rd**.

30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

MII)

111 Penn Street Baltimore, Maryland 21201

Chillum, Md

M. Kulell 31. Date filed (Month, Day, Year)

3 Suicide 4 Homicide

29a. Certifier

2005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			- 100001	State of Marylar				nd Mental H		Legible.	
			1 - For State Registrar	otato ot marytar	•	rtificate c			Reg. No	21111	5 15565
	DI		1. Decedent's Name (First, Middle, Last)	C 1-				2. Date of I	Death Da	/ Yeer	3. Time of Death
	Physici /Medio		John C.	COLE				April	2:	2000	5 12.50 P.M
	Examir	er	4a. Facility Name (If not institution give		-	66.	n, or Location of	1 6		County of De	2.4
	5	7	5. Social Security Number 6. Sec		last birthday)	If Under 1 Ye	Airy M		U'771		arroll inthplace (State or Foreign
Ċ	Funeral Director			M 2□F 78	Yrs.	Months Da	ys Hours	Min. (Month, I	Birth Day, Year)		rthplace (State or Foreign Country) Orth Carolina
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	reation					10d. Inside City Limits
	faryla show	ō									1 ☐ Yes 2√ No
	28a-i	Director	Maryland Prince Ge 10e. Street and Number	eorges Fo	rt Was	hington 10f. Zip Cod			10g. Cit	izen of What C	
	N with	i Di	7011 Haverhill S	Street		20	744			U.S.A.	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Amed Forces?	I.S. 13.			n? (Specify Yes or I Puerto Rican, etc.)		14. Race - Arr Black, Wh	
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Ö	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23e or 28e-1 show event, I're Medical Examena nust be notified at	ed b	15. Decedent's Edu			dent's Usual Oc	cupation		16b. K	Wr. ind of Busines	iite s/Industry
215	nin 72 in "na Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give		ne durina most o	of working			,
21	od with	Com	10		Me	chanic				ıtomobi	.1e
g	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) Crawford C. Col	l o			18. Mother's	s Name (First, Midd		- ,	
Z	should and Men amerke umetic	L _O	19a, Informant's Name/Relationship (Ty)		40h Maili	- A dd /C4d					Tin Code I
Maryland 21215-0036	id 2 st th and th and traur		Patricia Ann Cole	•							Zip Code 23451
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other		Virgini	20c. Lo	ocation - City o	r Town, State
E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State Me	tropol:	itan Cr	ematoriu	m 04/26/0	5 A	lexandr	ia, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service License	(·) .) 02	Name and Ad	dress of Facility	th P.A.,	Funai	al Hom	
Ш	E # 2.0.5		Movent L.	Williams	26	5401 Ric	dge Road	. Damascu	s. Ma	ryland	20872
E			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deal ne cause on each line.	in. Do not en	er the mode of	dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Broncho-pne							One Week.
Ť	Examiner			Due to (or as a consec Chronic Obs	11.0	ve pulm	onary Di	isease			Years.
	To the last	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated exect in the cause of the	Due to (or as a consec		vo Pazi.	.01.01	<u> </u>			icars.
	acutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	:							
760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) case	Due to (or as a consec	(uence of):						
687				1							
Box (n certifi inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn.		75				23d. Date of de	elivery
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown		∃Ectopic pregna ∃ Other (s <i>pecify</i>				Month	Day Year
P.O.	that the death certifica ed by the attending ph detached for use as th	Physician/Med	9 Unknown			. 4	2. 8	02- 04	d Anhanas .		An Abra - augus of danaba?
	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	b	Part II. Other significant conditions cor Hypertension	ithouting to death but not res	suiting in the u	nderlying cause	given in Part I.		TYes 2		to the cause of death?
Sor	v requ been should	etec	Parkinson's D					24a. W			autopsy findings available
Records,	The lavate has	ompleted						aut	opsy formed?	prior to death?	completion of cause of
Vital		e C	Senile Dement: 25. Was case referred to medical	La			26. Place o	1 ☐ Yes	2 🔯 No / one)	1 ∐ Ye	s ZZ No
	S & S	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Other: 4X Nurs	ing Home 5□Re	sidence	6 □Other (Sp	ecify)
n 0	ing Ph	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	,	njury at Work?	28d. Describ	e how injui	y occurred	
Division of	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st		1 □ Yes 2 □ No		(Street an	d Number or F	Rural Route Number,
Σ	after after Direction by	Certification:	4 Homicide determined	building, etc. (Speci	fy)	eet, ractory, on	ice		own, State		nuiai noute ivuitibei,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, deat	h occurred at th	e time, date and	place, and due to th	e cause(s)	and manner a	as stated.
	the Hi in 24 the Fu	Medical	one)	ner: On the basis of examina and manner stated.	ation and/or in			occurred at the time			
	With To To	2	29b. Signature and title of certifier	a landi	*.		ense number				nth, Day, Year)
	X			yan	- 00-1 ~		30469.		Apri.	25,	2005.
	9		N B Vellanki, 9055				licott C	ity, MD 2	1042.		
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Records,
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of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11:15 P M James Albert Capps April 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 51 Director 544-70-9390 13, 1954 Oregon Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is markad othar than "natural", or itams 23a or 28a-f shov traumatic avant, the Modical Examinating must be notified at 1 ☐ Yes 2 X No Maryland Howard Woodbine Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3444 Woodbine Road 21797 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married ☐Yes 2X No 1 ☐ Yes 2√ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be William Capps Dorothy White 2 permit. Pages 1 and 2 shi Department of Health and Important: If item 27 is ma any injury or othar trauma once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Capps - Wife 3444 Woodbine Road, Woodbine, Maryland 21797 Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 4/25/05 Alexandria, Virginia 21. Signature of Fure-ral Service Licenses Olin L. Molesworth P.A., Funeral Home overt 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Physician CANCER Jeans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Year Month 4☐Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1⊠'Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate 1 Yes 2 🗷 No or Attanding Phyaician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 COther (Specify) 2 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending Injury 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after a Funaral [29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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Registrar

6701 31. Date filed (Month, Day, Year) 32. Reginar's Signature

30. Name and address of person with completed datise of death (Item 23a) (Type, Print)

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A. Riley

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April 24, 2005

N. Charles St.

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** April Billy Wayne Chamblee 24 2005 10:58a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24836 Woodfield Road Damascus Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sacial Security Number 5 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 XM 2 □ F Yrs. Director 1927 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Damascus Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24836 Woodfield Road 20872 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electical Maintenance Foreman Potomac Electic Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Leslie Belmont Chamblee Nellie Pearl Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty G. Chamblee/ Wife 24836 Woodfield Road, Damascus, Maryland 20872 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2005 A □ Donation 5 □ Other (Specify) Damascus Methodist Cemetery Damascus, Maryland 22 Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 21. Signature Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesothelioma 6 Months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification; To 1 Yes 2 🔯 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, use as the ρ P.0. be detached Division of Vital Records, filled in by the funeral director, page 2 should this after death.

Funeral

the Maryland

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-1 shov traumatic event, it a healess Examinar in the multified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 s ment of Health an item 27

other

Physician

/Medical

Examiner

burial-transit

physician

within 24 hours a To the Funeral C completely To the

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

9707 Medical Center Drive Suite 300, Rockville, Maryland Joseph M. Haggerty M.D.

1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32407

29d. Date signed (Month, Day, Year)

April 25, 2005

State Registrar to Seple m. H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 47 **Physician** Daisy R. Cowan 2005 OCI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Harton itizens Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 KF 98 Yrs January 28,1907 Director 345-05-2151 ILUsual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 1 ☐ Yes 2 No Director Cecil Risina Sun MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1162 Ebenezer Church Road 21911 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: Completed by 3 Widowed 4 □ Divorced White "natural", al Hygiene. Jother than "natura ivent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental b permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked c any injury or other traumatic ever 9068. and Mental John Davis Bertha Bashman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 237 Blake Rd. Elkton, MD 21921 Elaine Robertson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04-27-2005 Rising Sun. MD * 4 ☐ Donation 5 ☐ Other (Specify) Rosebank Cemetery 22 Name and Address of Facility R.T. Fourd Funeral Home, P.A. 21. Signature of Funeral Service License S. Queen Street, Rising Sun, MD 21911 23a. Parl 1. Enter the disease, or complications shock, or heart failure. List only one caus hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stenosi Aurtic **Physician** 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Wasan autopsy performe 1∏ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2005

32. Registrar's Signature

hallans

Prashant Shukla, mo 155. Parke Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 400 / Therdeen MO 21001

000048050

4/22/05

	1- Stata Registrar		epartment of Health and N Certificate of Death	Mental Hygie	_	1556
	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physician /Medical	LILLIAN AGNES	CLARK		-	4, 2005	8:30 F
Examiner	4a. Facility Name (If not institution, give street	et and number)	4b. City, Town, or Location of Death		4c. County of Death	
	THE MAPLES		LA PLATA			RLES
uneral	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	place (State or Foreigntry)
ector	2//-12-9600	**' 81 '	rs.	DEC.16,	1923 COL	ORADO
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limit
TO.	MARYLAND CHARLES	LA P	ר א ריי א			1√Xes 2□N
traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	10e. Street and Number	1 DA F	10f. Zip Code	10g	. Citizen of What Cou	intry?
4 0	101 WESLEY DRIVE	, APT. # 109	20646		U.S.A.	
Funeral	11 Marital Status 12.1	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer	
E	1 Never Married 2 Married	Amed Forces: 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes XIXNo Specify:	o nican, etc.)	Black, White	, etc.
1 by	3√√Vidowed 4 □ Divorced	Year or Dates:	AANO Opeany.		Specify: WH	ITE
Completed	15. Decedent's Education (Specify only highest grade co	on 16a.	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 18	b. Kind of Business/I	ndustry
jdr		College (1-4or 5+)			HARLES C	
CO	12	1 JU	DGE of ORPHANS CO	OURT G ne (First, Middle, Ma	OVERNMEN	T
Be	17. Father's Name (First, Middle, Last)	Q.II			·	
D Patic	GEORGE F. BOWDI			M. ALLEN	Short Town Ctate 7	in Code)
or other traum	19a. Informant's Name/Relationship (Type,		Mailing Address (Street and Number or Ru			
other	CAROLE A. WOOD-DA 20a. Method of Disposition		527 SPRING HILL Disposition (Name of		RD. LA P	
	1 SyBurial 2 ☐ Cremation 3 ☐ Remo	oval from State cemeter	r, crematory or other place)			20
Jury	* 4 Donation 5 Other (Specify)		ETERS CEMETERY 4	-29 - 05_W	ALDORF, M	ARYLAND
any Injury or ODCE.	21. Signature of Funeral Service Licenses	M00479	P2. Name and Address of Facility RAYMOND FUNERA	. SERVIC	E. P.A.	
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ian cal	Immediate Cause (Final disease or condition resulting in death)	Pulmonary	tibrisis and			years
er		Due to (or as a consequence of	it): 			. 61
1	Sequentially list conditions,	Due to (or as a consequence of	0:			724)
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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edic	u					
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be detached by Physic	9 Unknown	9□ Unknown				
by P	Part II. Other significant conditions contrib	outing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
D D	Influenza /	<u>/† </u>		1 🗆 Yes	2 No 3 □ Pro	bably 4 Unknown
page 2 should Completed	1			24a. Was an	24b. Were aut	topsy findings availa
age mo				autopsy performe	d? death? 1 No 1 ☐ Yes	ompletion of cause
Be C	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	X-1	
I director, page 2	examiner? 1 ☐ Yes 2 ☐ No Hos	pital: 1 ☐ Inpatient 2 ☐ ER/Ou	04		ce 6 Other (Spec	ufy)
	27. Manner of Death		ime of 28c. Injury at Work?	28d. Describe how	injury occurred	
atio	1 Natural 5 Pending 2 Accident investigation	,,	M 1 ☐ Yes 2 ☐ No			
tific by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ed in by the funera						
cai cai			, death occurred at the time, date and place door investigation, in my opinion, death occurred.			
Medical	one)	and manner stated.				
000	29b. Signature and title of certifier	_	29c. License number	290	I. Date signed (Month	
	7 4	~ \	D003342	-6	4-25-0	۲۰
	30. Name and address of person who comp			No. 1	2	
	B. Larry Senior 5 J	cmb. 111 L	a Errange Ave, L	arlata.	MD 30	1046
State Registrar	31. Date filed (Month, Day, Year) MAY 0 9 2005	32. Registrar's Signa Gre	v ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Martha G. DuBose 1:27 P M May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Health Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🗶 F 225-84-8476 April 9, 1917 88 Yrs. Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10716 Etzler Mill Road 21798 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No þ Specify: Specify: White 3 XWidowed 4 Divorced Completed 15. Decedenl's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph S. Gresham Mary T. Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warner DuBose/Son 10716 Etzler Mill Road, Woodsboro, Maryland, 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory May 4, 2005 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 106 East Church Street M& Millian Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 27 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that include grand and the cause (Disease). Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, oulcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical

Funeral

Director

the Medical Examinar must be notified at

'natural', or Items 23g

nd 2 should be filed within alth and Mental Hygiene 27 is marked other than ' r traumatic avent, the Me

iges 1 and 2 s

permit. Page Department of Important: If any injury or once.

Pages 1

Baltimore,

P.O.

of Vital Records,

Hospital or Attending Division

within 24 hours after death To the Funeral Diractor:

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

25. Was case referred to medical 26. Place of Death (C

perfo	rmed?
Check aply o	nne)

1 ☐ Yes 2 ☐ No

	1 🗌 Yes	2000
2	7. Manner of	Death
	1 DMatur	al
	2 Accid	leni

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Hursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

Place of Injury - Al home, farm, street, faclory, office building, etc. (Specify)

1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and little of pertifier

29d. Dale signed (Month, Day, Year)

10

State Registrar

31. Date filed (Month, Day, Year 09

JAMES DAVIS Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. **Physician** Day Year James Davis Jr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4b. City, Town, 4c. County of Death Examiner BA/ /timore TIMORE 8 Date of Birth (Month, Day, Year) Country)
Tune 11, 1936 Mayesville, If Under 1 Year | If Under 24 Hrs. Funeral 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Hours Min. 1(XM 2□F 68 Director 577-48-6245 Yrs Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at Director 1X Yes 2 □ No MD Pikesville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a. 816 Sturgis Place 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver **HOspital** 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAmes B.T. Washington Davis, Sr. Charlotte McDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3200 Steed Rd. Ft. Washington, MD. 20744 Kristy Frizzell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 Cremation 3 Removal from State ŏ * 4 ☐ Donation 5 ☐ Other (Specify) HArmony Memorial Pk. 4-29-05 injury LAndover, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MArshall's Funeral Home any 4217 9th. St. N.W. Washington, D.C. 20011 23a. Par. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each fine. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) set and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even to the conditions of the con Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 💆 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 2 No 1 Tyes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 hpatient P 2 ER/Outpatient 3 DOA s after death.
I Director: After this
of in by the funeral d Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) within 2 To the and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, APR 2 6

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend 18, per fh, g919 9-29-11 sm
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	Cei	rtificate of			J. No.	10016
	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	2 2005	3. Time of Death
	Physicia /Medic		Amora Donalds					April 2		7:35 P M
	Examin	er		of institution, give street and number) 4b. City, Town, or Location of Death					4c. County of Deat Anne Arui	
-				rundel Medical Center Annapolis fity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H				8 Date of Birth		
	Funeral Director			1 ☐ M 2 💢 F	7. Age (III y/o. last ontiony)		8. Date of Birth (Month, Day,) Nov. 19,	1939 New	nplace (State or Foreign untry) Jersey	
	and w		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary feh	ţ	MD Prince (George's	Bowie					1∭XYes 2 ☐ No
	r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	h with		3110 Tinder Plac	ce		20	715		USA	
	deat Bms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow emprishing or other traumatic event. Ite Medical Evantment to notified at ance.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2▼N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite
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2	Men ,	Completed	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+}	<i>bo not use retire</i> Ceacher	<u>"</u>)		ublic Sch	001
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and	d be	Be C	Edward McCabe				Metaxcia	''Unkn	own" Para	Kevopolis
<u> </u>	Shoul nd Me mark mati	ပ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street	and Number or Run		City or Town, State, 2	
S	nd 2:		James T. Donalds	on / spouse	3110	Tinder P	lace Bow	ie, MD. 2	20715	
re,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date 2	0c. Location - City or	Town, State
E	Page nent c int: If		1 ☐ Burial 2 🏋 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State ify)	Metropoli	itan Crem	atory 04/		Lexandria,	VA.
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687	ifficate g phy as the	edical								
O. Box	e law requires that the death cer has been signed by the attendin ye 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of de Month	livery Day Year
Δ.		by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to s 2 No 3 □ Pt	the cause of death?
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ion of	ling After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Wo	ryat irk?]Yes 2∐No	28d. Describe how	w injury occurred	
Division	Diffe of	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	Hospite 4 hours Funerel	edical C		Physician: To the best aminer: On the basis of and manner sta	f examination and/or i					
	To the within 2. To the complet	Me	29b. Signature and title of certifier	0-		Ì	se number	29	d. Date signed (Mon	th, Day, Year)
	F S F O		A Strake	W.D.	MD	DS	8510		04/22	105.
)	(5)		30. Name and address of person who step them	o completed cause of d	leath (Item 23a) (Type	o, Print) OO1 Medic	al Pkwy.	Annapol:	is, MD. 21	
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2 6 200	2. Registr	ar's Signature	S. s		*		

Funeral Director

filed within 72 hours after death with the Maryland r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at "natural", or Is marked other than Mental permit. Pages 1 and 2: Department of Health ar Important: If itam 27 Is any injury or other traugues.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-transit signed by the a been certificate To the Hospital or Attending Physician: this After thi funeral Diractor:

Division of Vital Records, P.O. Box 68760,

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 8:45AM Deborah Α. Durham APRIL 20 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Doctor's Community Hospital Prince LAnham George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2⊠F Yrs. 577-76-1316 50 Feb. 24, 1955 Washington, Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Counts 10d. Inside City Limits 1-Yes 2 No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 USA Funeral 34 New York Ave. N.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Riggs Bank Clerk 2 Yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Paul Durham Bernice Segars 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul Durham, Jr./Brother 34 New York Ave. N.W. Washington, D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. National Mem. Pk. 4-28-05 1 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 Kall Mars 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Dug to (of immune deficiency Syndran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that include any leading to the conditions of th Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) Yes 20 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1™ Yes 2 No 1'□(Inpatient 2 □ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 26 2005

Registrar

State

within 24 hours a To tha Funeral C

			1 - State Registrer	State of Ma	ryland / Depa <i>Ce</i>	artment of H			giene Reg. No.)	by jobs, prove	
	4		Decedent's Name (First, Middle, Last,)				2. Date of Dea		JUb	3. Tiple of Death
	Physici /Medio			NOTTAC)			Month	Day 20	200S	17:50M
	Examir	ner	4a. Facility Name (If not institution, give Montgomery General		1	4b. City, Town, o	or Location of Deat y	h		nty of Death ontgome	ery
	Funeral Director		5. Social Security Number 6. Set 577 –84 – 0677	7. Age	(In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1904	9. Birth Cour Wash	place (State or Foreign ptry) Lington, DC
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	I0d. Inside City Limits
	e Mary	ctor	Maryland Montgon	nery	Chevy	7 Chase					1 ∑ Yes 2 □ No
	th with the 23a or 28	al Director	10e. Street and Number 4515 Willard Avenu	ıe		10f. Zip Code 20	815	ł .	-	of What Cour State	
980	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, The Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	E	Race - Americ Black, White, acity: whi	etc.
21215-0036	filed within 72 he Hygiene. khar than "natui int, the Wedfort	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo.	rking		f Business/In	dustry
land 2		To Be Co	17. Father's Name (First, Middle, Last) Morris Allex					me (First, Middle, e (unknov		name)	
Maryland	and s m	-	19a. Informant's Name/Relationship (Ty Gerald Datlow, Sor		19b. Mailii 9039	ng Address (Street Sligo Cr	and Number or Ri	way #208	r, City or Too	wn, State, Zip er Spr	Code)
Baltimore,	mit. Pages 1 and 2 partment of Health ortant: If itam 27 I injury or other tre		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☒ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo	osition (Name of matory or other pla	ce) 04/2	Date 6/05	20c. Locatio	on - City or To	own, State
Balti	permit. Pages Department of I Important: If its any injury or of		21. Signature of Fineral Cervice Ligens	00		rchinsky 4 Carrol				DC 2	20012
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	he death. Do not ent	er the mode of dyle	ng, such as cardiae	c or respiratory arr	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions,	U24 .		ENA					
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CONC	Consequence of):	E HE	ART	FAIL	UKE		
68760,	ficate be executed physician and s the burial-transit	edical Ex	resulting in death) Last		consequence of):	A					
.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year
ם	juires that signed by lid be deta	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.		bacco use co		ne cause of death?
Records,	The law requir ate has been si page 2 should l	Completed						24a. Was a autops perform	sy	prior to cor death?	psy findings available mpletion of cause of
Vital	ician: T certifical rector, p	0	25. Was case referred to medical				26. Place of Dea	ath (Check only or			
>	ys dii	To B	examiner? 1 ☐ Yes 2 ∰No	lospital: 1 ∰Inpatien	t 2 ER/Outpatier	nt 3 DOA Ct	200	lome 5 ☐ Reside		Other (Specifi	y)
on of	iding Ph th. : After th funeral		27. Manner of Death 1 ₺ Natural 5 Pending 2 △ Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur		28d. Describe ho			
Division	Hospital or Attending 24 hours after death. Funaral Diractor: Afte tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Nu n, State)	mber or Rura	l Route Number,
	To the Hospital of within 24 hours all To the Funeral D completely filled it	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and late and plac	manner as st	tated. the cause(s)
)	To tha within 2 C To tha Complet	M	29b. Signature) and title of codifier	Mu		29c. Licens	59 number		29d. Date sig	ned (Month,	Day, Year)
			30. Name and address of person who co		ath (Item 23a) (Type,		Prince 1	Philip Dr	., Ol	ney, M	D 20832
	Sta		31. Date filed (Month, Day, Year)	3 Registrar	's Signature	de					

			_	ype or Print in I State of Marylar	nd / Depa		Health and M	lental Hygi	ene g. No. 2005	15575
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Ronald S. Dutter Aa. Facility Name (If not institution, give st.)			4b. City, Town,	or Location of Death	2. Date of Death Month April	Day Year 22 200!	5 10:00 a ^M
Ī	Funeral Director		160-36-3054	7. Age (In yrs.	last birthday,	Taneyt If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, March 2	Carro Year) 9. B 1948	L1 inthplace (State or Foreign Country) PA
preloceM of	Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Carrol		ty, Town or L Tane	ytown				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the with the	ns 23a or 2	Funerai Dire	5133 Babylon Road	2. Was Decedent Ever in L	J.S 13.		787 Hispanic Origin? (Spoan, Mexican, Puerto		g. Citizen of What 0 USA 14. Race - An	nerican Indian,
DOOD O	triben. Triben "natural", or flems 23a or 28a-f show Tre Madical Examiner must be natified at	by	1 Never Married 2 Narried 3 Widowed 4 Divorced	If Yes, Give 1 Year or Dates:	971	1 ☐ Yes 2 🕵 No	Specify:		Black, Wh	White
G Z I Z I D-0030	giene. or then "nate	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usual Occu e kind of work done DO NOT use retire Sales Cle	e during most of work ed)	ing	6b. Kind of Busines Super Mai	·
_ 9	2 2 2 3	To Be C	17. Father's Name (First, Middle, Last) James Duttera	a Print)	10h Mail	ing Address (Strag	18. Mother's Name France of and Number or Rura	ces Hoove	er	Zin Code)
ໜໍ່ ເ	Health a am 27 la ther tree		19a. Informant's Name/Relationship (Type Sandra Duttera/wif 20a. Method of Disposition	e 20b.	513	Ing Address (Streets 3 Babylo osition (Name of Smatory or other placets)	n Road Ta	aneytown,		37
baitimore,	Department of Importent: If its any injury or or one		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	State	Mary	's Cemet	1 1 .	7/2005 Home	Silver R	ın, MD 17340
p	hysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	enel	nter the mode of dy	Avenue I ing, such as cardiac of Carcino	or respiratory arre	N_{M}	Approximate Interval Between Onset and Death
on,	ician and burial-transit	ical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Inderlying Cause (Disease or iriginy that initiated events resulting in death) Last d.	Due to (or as a conse						
r.o. box 60	the death certificate y the attending physiched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnan	су		23d. Date of o	letivery Day Year
ras, r	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions cond	ributing to death but not re		underlying cause g	iven in Part I.			to the cause of death? Probably 4 Inknown
al Reco	yercient: Ine law r is certificate has be director, page 2 sh	Completed						24a. Was an autopsy perform	prior to death'	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
DIVISION OF VITAL RECORDS,	To the hospital of Attending Projection: The Law requires that the beart continuate within 24 hours after death. within 24 hours after death. Conflict the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	ther: 4 Nursing Houry at ork? Yes 2 No	28d. Describe how	nce 6 Other (Sp w injury occurred	
בוב בוב	spital or At ours after d ierel Direct filled in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Specials: To the best of my kr	ify)			City or Town,	, State)	Rural Route Number, as stated.
:	within 24 hours after the Eunerel Direction of completely filled in	Medical		er: On the basis of examinand manner stated.		nvestigation, in my		red at the time, da	ite and place, and d	ue to the cause(s)
	10 St	ate ⁻	30. Name and address of person who confidence of the confidence of	32. Registar's Sign	555	S. Can	ter St.	West	m.43+セル	, md. 2115

			1 - For State Registrar	State of Maryland /	Depa		f Health	and Me	ental Hy		•	15576
			1. Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physici		Walter Roy Day, Sr.						Month	20 Day	2005	12024M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	n, or Location	n of Death		4c. C	ounty of Death	·
	Examin		2336 Sams Creek Rd	l •		Westmi	nster			Car	roll	
	Funeral		5. Social Security Number 6. Sex		birthday)	If Under 1 Y			B. Date of Bir (Month, Da	th V Year	9. Birth	place (State or Foreign ntry)
	Director		213-30-8228 ¹ \overline{\text{x}}	M 2□F 73	Yrs.	Months Da	ays Hours		May 17			vland
	p		Usual Residence of Decedent	10-0-7								
	srylar show	ڀ	10a. State 10b. County	10c. City, To	own or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f	Funeral Director	Maryland Carroll	Westmi	inst							
	or 2	ä	10e. Street and Number			10f. Zip Co				10g. Citize	n of What Cou	ntry?
	ath w	ā	2336 Sams Creek Rd.			211.					d State	
	tame	n n	Tr. Maria Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent If Yes, specify (of Hispanic C Cuban, Mexic	Origin? (Spec an, Puerto R	ify Yes or No ican, etc.)	- 14	. Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2🕱	No Specif	' y:		S	pecify: Whi	ite
Ö.	within 72 hours after death with the Maryland ene. than "natural", or Itama 23e or 28e-1 show the Modical Examilier must be notified at	pe p	15. Decedent's Educ		Sa Dece	dent's Usual O	counation			16h Kind	of Business/In	dustry
<u>.</u>	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work do	one during mo atired)	ost of working	9	TOD. TUITO	0. 5431103411	dustry
12	with lene. thar	mo	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	lasor					Self-	employe	he
0	be filed ital Hygi d other evant, I	Be C	17. Father's Name (First, Middle, Last)				18. Mot	her's Name	First, Middle,			- 54
an	id be ental ked ic ev	To B	William Earl Day				Pea	arlie	M. Wri	ght		
Maryland 21215-0036	should ind Men s marke umatic	-	19a. Informant's Name/Relationship (Type	oe, Print) 1	9b. Maili	ng Address (St	reet and Num	ber or Rural	Route Numbe	er, City or T	own, State, Zip	o Code)
	alth a		Debra Dorsey (daugh	ter) 12	28 Mc	orning 1	Frost S	St. Ta	neytow	n, MD	21787	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or Itama 23e or 28a-1 show any injury or other traumatic event, Its Medical Examinational be natified at once.		20a. Method of Disposition	come	of Dispo	osition (Name o	f place)	Da	te	20c. Loca	tion - City or To	own, State
E	Page lent c nt: If		1 ☐ Burial 2 【Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ll Crema		4/24/2	005	Winf	ield. M	m -
alti	mit. partm sorts / inju		21. Signature of Funeral Service License		p.25	2. Name and A	ddress of Fac	ility	1 11	1	o .	ory, P.A.
m	Per in De		* All k	Ulle	12	212 West	t Old 1	runera Libert	ı ноте v Rd.	and Winfi	eld. MD	ory, P.A.
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due ty (or as a consequence	ul	ter the mode of	dying, such a	as cardiac or	respiratory a	rrest,		Approximate Interval Batween Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du								3 days 2 years
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		□Ectopic pregn □ Other (specif				23	d. Date of delive Month	ery Day Year
٥.	that	by Pt	Part II. Other significant conditions con	tributing to death but not resultin	g in the u	inderlying cause	e given in Par	t I.	23e. Did t	obacco use	contribute to t	he cause of death?
rds	quires n sign								1 🗆 `	Yes 2	No 3□Prob	bably 4 □Unknown
l Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24b. Were auto prior to co death? 1 \sum Yes	opsy findings available impletion of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					ce of Death	Check only o	one)		
of/	G	은	To tes ZA No	ospital: 1 Inpatient 2 ER/	-35				-		Other (Specif	fy)
ט		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	. Time o Injury		Injury at Work?		3d. Describe I	how injury o	occurred	
sio	Attending r death. ector; Afte by the tune	cati	2 Accident investigation 3 Suicide 6 Could not be				1 □ Yes 2 [-				
Division	i or Attendater death Director:	ertification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	farm, st	reet, factory, of	fice	28	City or To		Number or Hura	al Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edicai Ce		sician: To the best of my knowled her: On the basis of examination and manner stated.								
	o the	Me	29b. Signature and title of certifier			29c. Lie	cense numbe	г		29d. Date :	signed (Manth,	Day, Year)
)			16/1 /a/ m	uldlita min		75	154	102		41	1/2	
	Mar		30. Na le and address of person who co	mpleted cause of death (Item 23	a) (Tvoe	Print)	~ > L	7)	0	110	1/2	103
	8		Talm by Middle	ton 6881	0001	le Dr	ad	West	mist	CY	1/2 hoa	11.57
-	Sta Registi		31. Date filed (Month, Day, Year) APR 2 5	32. Registrar's Signature		San H			Dre	,		

DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	
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		For State Registrar		State o	of Marylar	-	artment of H				jiene		gither process every except
q		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	/ U U	3. Time of Death
Physicia /Medica				VERA I	COUISE	DAVI	DSON			APRIL		Year 2005	1:15 A M
Examine	er	4a. Facility Name (If n		_	mber)		4b. City, Town, or					unty of Death	
		LOOKABOU'		OR			WESTM:				CA	RROLL	
Funeral		5. Social Security Nun		3. Sex 1	7. Age (In yrs.		Months Days	If Under Hours	24 Hrs. Min.	Date of Birth (Month, Day	, Year)	9. Birthp Coul	place (State or Foreign ntry)
Director		220-26-5 Usual Residence of D			7	6 115.				3/22/	1929	MARY	LAND
MO TO	Ì		0b. County		10c. Ci	ty, Town or L	ocation					1	0d. Inside City Limits
ts pa	ţō	MD.	CARRO	LL	W	ESTMI	NSTER						1∭Yes 2 ☐ No
r 288	Directo	10e. Street and Numb	er			1	10f. Zip Code			1	0g. Citizen	of What Cour	ntry?
23a 0		29 WASH	INGTO	N RD.			2115	57			USA		
ems ar m	Funerai	11. Marital Status		12. Was Deci	edent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Ori	igin? (Spec	cify Yes or No-		Race - Americ	
a E		1 Never Married			21 No			Specify:		noarr, etc.)		Black, White, ecify: BL_{i}	
ural Ex	d by	3 Widowed 4		Year or D									
nat	Completed		5. Decedent's only highest	Education grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing mos	t of workin	9	16b. Kind o	of Business/In	dustry
than than	m l	Elementary/Second	lary (0-12)	College (1-4or 5+) 3		TLE ANAI				зоок	WAREH	IOUSE
ant, la	a l	17. Father's Name (Fi	rst, Middle, La		<u> </u>			18. Mothe	er's Name	(First, Middle,	Maiden Sur	name)	
ked ic av	0			LONNIE	C	H	AWARD	HA	TTIE	:]	BOWEN	Ī	
e ma		19a. Informant's Nam	e/Relationshi	p (Type, Print)		19b. Mail	ing Address (Street a	and Numbe	er or Rural	Route Number	City or To	wn, State, Zip	Code)
n 27 i n 27 i er tra		VELDA L.	DAVI	DSON D	AUGHTE	R 29	WASHINGT	ron i	RD.,	WESTMI	NSTE:	R, MD	. 21157
f itan		20a. Method of Dispos		B.⊒Removal from	State	cemetery, cre	osition (Name of matory or other place			300	20c. Locati	on - City or To	wn, State
ment ant: ury o		`4 Donation 5			MT		CEMETER	1	4/25			TOWN,	
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avant, Ite Medical Examinat must be nullised at once.		21. Signature of Type	ral Service Li	censee			2. Name and Addres						
2 = e Ol)				54 E. MA					R, MD	
1			allure. List of	omplications that only one cause on e	each line.	th. Do not en	ter the mode of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
ysician		Immediate Cause (Findisease or condition resulting in death)	nai	_ a	1	leme	win						
Medical aminer		, ,		Due to	(or as a confec	quence of):							
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ial-tra	Exa	that initiated events resulting in death) Las	st	c. Due to	(or as a consec	quence of):							
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tendi or use	Physician/M	23b. Was decedent p			tcome of pregnation in the 2 Tests		⊒Ectopic pregnancy					Date of delive	<u>.</u>
the a	Sici	1 ☐ Yes 2 ☑ 9 ☐ Unknown		4⊟Pregn 9⊟Unkno	nant at time of o own	death 5	Other (specify)					Month	Day Year
detac		Part II. Other significa	ant condition	s contributing to de	eath but not res	sulting in the I	inderlying cause give	n in Part i		23e Did tol	acco use c	ontribute to th	e cause of death?
sign d be	d by	District	s Mel	like TT	Co. P.	0	acteom	vo si			s 20 No		abiy 4 □Unknown
shoul	ete		, , , ,		1001	7	o) so po	1 - 1 1		24a. Wasa	. 124	h Mara auto	nov findings available
e has	ompieted									autops	y ned?/	prior to cor death?	psy findings available appletion of cause of
ificate or, pa	ပို	25. Was case referre	o medical					OC Disease	of Dooth	1 Yes 2		1 🗌 Yes	2 🖻 No
s cert direct	0	examiner?		Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Othe	r		Check onl on		Other (Specify	ASSISTER
heral	on:	27. Manner of Death	.550		of Injury th, Day Year)	28b. Time o				3d. Describe ho			LIVING
in: Aff		2 Accident	5 Pending investiga	tion	in, buy rour,	пцигу		r ∕es 2⊟i	No				
iracto	ertificati	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed 286. Place	of Injury - At h	ome, farm, st	reet, factory, office		28	Bf. Location (St City or Town	reet and Nu , State)	mber or Rura	l Route Number,
urs at ural D led ir	S		<u>a</u>										
within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2	Certifying Medical Ex	caminer; On the ba	asis of examina	owledge, deal ation and/or in	h occurred at the tim vestigation, in my op	e, date and inion, deat	d place, ar th occurred	nd due to the ca d at the time, da	iuse(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
o tha	Med	one) 29b. Signature and tit	1	and mani	ner stated.		29c. License					ned (Month, I	
3 - 8			1/6	4/11	1111	Y	12	75	GG		11	.010	X 1 .
1244		30. Name and address	s of person w	no completed cau	e of death an	n 23a) (Type	Print)	ノフン	11		41	1110	. ·
٦		PHILIP J	1.	BARSKY			rport đị	r.,We	estm	inster	, Md	. 211	58
State	-	31. Date filed (Month,	Day, Year)	32. R	egetrar's Signa	ature							
Registra	r		APR 2	L 2005	Ben	Jr.	Could						

JET Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02754 State of Maryland / Department of Health and Mental Hygiene Andrew Henry Doyle 15578 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Abril 19 2005 Year **Physician** Andrew Henry Doyle 12:35 Pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Dec. 3, 1934 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 T F 70 216-32-5224 MD Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r Itams 23a or 28a-f show ther must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 X No **Funeral Director** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 617 Tranton Road 21061 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No 6 White 1 ☐ Yes 2 XNo Specify: "natural", or Specify: δ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Electrical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Residential/Commercial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fill Health and Mental Hitam 27 is marked otill other traumatic evan Andrew H. Doyle, Sr. Anna Kriss ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 iment of Health a lant: If itam 27 is jury or other tra Joseph A. Doyle/Son 7249 Baltimore & Annapolis Blvd., Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr. 21, 2005 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Onset and Death In mediate Cause (Final disease of condition resulting in death) browning and hypothermia complicating atheroscleratic cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

Pnysician /Medical Examiner

21215-0036

Baltimore, Maryland

Records, P.O. Box 68760.

Division of Vital or Attending Physician:

Completed Be P Certification: After death. Diractor

2 No 1 X Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

subject drowned and exposed to Cold 281. Location (Street and Number or Rural Route Number, City or Town, State) chesepeake Bay. Thomas

Baltimore, Maryland 21201

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Pt and Bloody Pt. Annapolis Chesapente Ba

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 No

111 Penn Street

hi, m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

4-19-05

OCME April 20 2005

LING LI, MID 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

Yes 2□ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

32. Resistrar's Signature

Registrar

within 24 hours a To the Funaral D Hospital

Medical

1 Inpatient 2 ER/Outpatient 3 DOA

11:00 AM

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			1 - For State Registrar	Olu	10 01 11	iai y iai io	•	tificate					Reg. No	200	15	150	579
			Decedent's Name (First, Middle	e, Last)								2. Date of De Month			V	3. Time of	f Death
	Physicia /Medic		Alice B. Graha	am Fiel	.ds							April	24	200	Year 5	7:30	A M
	Examin		4a. Facility Name (If not institution	n, give street a	nd number)		4b. City,	Town, or	Location of	of Death		4c.	County o	of Death		
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			Usual Residence of Decedent									nay 5,	1/1/		1140		
	how		10a. State 10b. County			10c. City,	Town or Lo	cation							1	0d. Inside C	
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	vith th	Funeral Director	10e. Street and Number	-				10f. Zip		.01			10g. Citiz		hat Coun	try?	
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	iter de	Fun	11. Marital Status 1 □ Never Married 2 □ Married	ned 1	ned Forces Yes 21X	?						ecify Yes or No Rican, etc.)			, White,		
936	urs a	ğ	3 X Widowed 4 □ Divorced	I If Y	es, Give ar or Dates:			1 ☐ Yes	2X No	Specify:				Specify:	B1a	ck	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examination must be notified at	Completed	15. Deceden (Specify only highe	t's Education	oleted)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occupa	ation during mos	t of work	ing	16b. Kir	nd of Bus	siness/Inc	iustry	
121	within ne.	ig I	Elementary/Secondary (0-12)	Col	llege (1-4or	5+)	life.	Nurs)			Hoa	1+h (Care		
2	filed v Hygie ther t		12 17. Father's Name (First, Middle,	Last)				Nuls	e I	18. Mothe	er's Nam	e (First, Middle,					
Maryland	should be filed with and Mental Hygiene is marked other than sumatic event, the	To Be	Glover Evans							Su	sie	Harris					
ary	should and Men marke	-	19a. Informant's Name/Relations	hip <i>(Type, Prii</i>	nt)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Numbi	er, City or	Town, S	State, Zip	Code)	
	1 and 2 Health a sem 27 is		Stuart L. Graha	am / So	n		1801	-			е	Bowie,	MD.	207	21		
ore	of He of He fitem		20a. Method of Disposition 1 □Burial 2 □ Cremation	3 □Remova	I from State	20b. Pla	ace of Dispo metery, crei	sition (Nan natory or o	ne of ther plac			Date	20c. Lo	cation - C	City or To	wn, State	
Ĕ	Pages ment of the		`4 □Donation 5 □ Other (S	pecify)		0ak	k Hill					0/2005			e, 0	hio	
Baltimore,	per it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam and content traumatic event, the Medical Exam and content to colline at 900.		21. Signature of Funeral Service	Litense	00							all Fun				_	
m	40260		23a. Part1. Enter the disease, or	complications	ethat cause	ed the death		512 N						U	2071	Approximat	te
Q.			shock, or heart failure. List Immediate Cause (Final	only one caus	se on each	line.				-			,			Onset and	tween
	Pnysician /Medical		disease or condition resulting in death)	a	Oue to Cra	s a conseque	ence of):	art	00	uilo.	10					341	2
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	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		oue to (or a	s a consequ	anda ut):					7					
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687	licate physics the			d	101	6	1 . 47	1 1 4	C / C	371	-					7	<u> </u>
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	death	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4		2 ☐ Fetal of dea		Other (sp						Mont	th	Day ³	Year
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Vital	in: Th	e Co	25. Was case referred to medica	1						26 Place	of Deat	1 ☐ Yes	2 No	1 (^{2□} № Assist	ted
>	Physician: this certificanal director,	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospita	l: 1 ☐ Inpat	tient 2 🗆 E	R/Outpatie	nt_ 3 🗆 DC	Othe			ome 5 Resi		Other			
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Division	or Att fter d Jirect in by I	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		. Place of Ir building, e	njury - At hor etc. <i>(Specify)</i>	ne, farm, st	eet, factory	, office			28f. Location (City or To	Street and wn, State)	i Numbe	r or Ru r a	l Route Num	iber,
	pital	S	29a. Certifier 1 ☐ Certifyi	na Physician:	To the hes	st of my know	vledne deat	h occurred	at the tim	ne date an	nd place	and due to the	cause(s)	and man	iner as st	ated	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	(Check only 2 Medical one)	Examiner: Or	n the basis id manner s	of examinati	on and/or in	vestigation	in my op	oinion, dea	th occur	red at the time,	date and	place, ar	nd due to	the cause(s	3)
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12	-121		30. Name and address of person						τ.τ.	agh	ata-	D C					
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FACABAUGH, RUSA Baltimore, Maryland 21215-0036

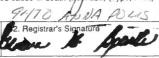
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To B	0	Robert As	kew					Anna I	Basden				
temu T		19a. Informant's Name/Rela	tionship (Ty	рө, Print)		19b. Ma	iling Address (Street	and Number or Rui	al Route Number	City or Town	n, State, Zi	p Code)	
ar tre		Patricia L	outhar	ı (Daugi	hter)	570	3 Westgate	e Road, La	anham, M	D 2 <mark>070</mark>	6		
othe		20a. Method of Disposition				Place of Dis	position (Name of rematory or other plac		Date	20c. Location	- City or T	own, State	
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any inji once.		21. Signature of Funeral Se	vice License				22. Name and Addre	ess of Facility Rer	ndon/Hale	e Fune	ral H	ome	
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¥ 7	2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregna 9□Unknov	int at time of o wn	death !	5 ☐ Other (specify) _					,	
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To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within To the comple

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)
APR 2 6 2005



234860

		1	For State Registrar	State of Mai	ryland		rtment o			nd Me		giene	15	15581	
	Physicia	_	1. Decedent's Name (First, Middle Roger Bro	Last) oke Farqul	har						2. Date of De Month April	Day	Year 2005	3. Time of Death 12:18 P M	
	/Medic	al -					4b. City, Tow	m or loc	eation of C		Aprii		y of Death	12:16 F	-
	Examin	er	4a. Facility Name (If not institution, Friends Nurs						pring				ntgon	nerv	
					(In vrs. la	ist birthday)	If Under 1 Y		Under 24	-	3. Date of Birt				-
	Funeral Director		166-01-3014	1 5 M 2□F	89	Yrs.	Months Da	ays H	ours !	Min.	(Month, Da June 1	h y, Year) 6 1915	Penr	place (State or Foreign ntry) nsylvania	_
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	show	5	10a. State 10b. County Md. Mon	tgomery	roc. Ony,		Sprin	a						1 ☐ Yes 2 No	
	he M	Director	10e. Street and Number	-51			10f. Zip Co					10g. Citizen of	What Cour	ntry?	-
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	ns 23	era	11. Marital Status	12. Was Decedent Ev	er in U.S	S. 13. V	Vas Decedent Yes, specify	of Hispar			ify Yes or No	- 14. Ra	ce - Americ		
0	filed within 72 hours after death with the Maryland Hygiene. sthar than "netural", or Itams 23a or 28e-f show sthar than "netural", or Itams 23a or 28e-f show snt, Ita Motest Experiment	Funeral	1 ☐ Never Married 2 Marri	Armed Forces? ad 1 XYes 2 No	19	40-1	Yes, specify	,		Puerto Ri	ican, etc.)		ick, White,	etc.	
<u>න</u>	rai', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	19	45	Tes 2j2	NO SE	pecify:			Speci	ry: V	White	
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Maryland	d be f ental H ked o	To Be	,	Farquhar, J	r.				Ma:	rjor	ie Ho	olt			
3	shoul nd M mar	-	19a. Informant's Name/Relations	nip (Type, Print)								er, City or Town			
	alth a 27 is		Thomas Farqu	har / Son		1061	1 Fall	s Ro	ad,	Poto	mac, M	Maryland	208	354 	
ore,	of He of He litam		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name on natory or other	of r place)		Da		20c. Location			1
Ĕ	Dag ment		'4 □Donation 5 □Other (S)	pecify)	Me	tropol	itan C	rem.		4/22	/05	Alexa	andria	a, Va.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "netural", or Itams 23a or 28e-f show any injury or othar traumatic event, It a Madest Examing or ust be notified at once.		21. Ignature of Furleral Strvice	icensee m - c	0046	70 22	Name and A Muri P. O	ddress of eIH	· Ba:	rber	Funer Layto	al Home	e, Md	. 20882	
Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed The law requires that the death certificate be executed This certificate has been signed by the attending physician and The law reduction is a second of the death of the	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (clisate or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No	sphagio	consequiconseq	ence of): ence of): ence of): ncy death 3 =	Ectopic pregr Other (special inderlying cause	e given in	3. Place o	sing Hom	24a. Was autoperfo	obacco use col Yes No an 24b psy propad? No one) dence 6 0	3 ☐ Prof. Were autoprior to codeath? 1 ☐ Yes	the cause of death? bably 4 Unknown posy findings available ampletion of cause of	
o	Phys or this oral di		27. Manner of Death	28a, Date of Injury	/	28b. Time of		Injury at Work?				how injury occu		,,	
on	nding I th. : After e tuner	atlor	Natural 5 Pendir		Year)	Injury	М		2 🗆 No	0					1
Division of	Hospital or Attanding 24 hours after death. Funaral Diractor: After tely filled in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ				eet, factory, o	ffice		28	8f. Location (City or To		ber or Run	al Route Number,	
	To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Medical C		g Physician: To the best o Examiner: On the basis of and manner stat	examinat										
	To th To th	M	29b. Signature and title of certifie	1			29c. L	icense nu	ımber		and the same of th	29d. Date sign	ed (Month,	Day, Year)	
	541		Quint	tru M	0_		-	31	24			lord	21):	2005	
	S . !		30. Name and address of person			23a) (Type,		UNIS		ANNO	N, M.D.	1 0 2/ 0	210	27	
			31. Date filed (Month, Day, Year)	-	ZING r's Signal			ころ	157	, 10	117124	CANP	202) >	-
	Sta Regist			2005 April 2005	K	Apar	E.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State
Registrend item #10a-f per inf 88/15 Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 3. Time of Death Month Day Year HILDA BARBER GOFORTH /Medical MAY 2005 4a: Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER I API ATA
If Under 1 Year | If Under 24 Hrs. CHARLES 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day; Year) 1 M XXF Days Birthplace (State or Foreign Country) Months Director Hours Min. 238-09-3688 Usual Residence of Decedent Yrs. 91 MAR. 28, 1914 NORTH CAROLIN 10a. State 10b. County ir then "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at 10c. City, Town or Location NC 10d. Inside City Limits Funeral Director PLATA KINGS MOUNTAIN CHARLES 1 ☐ Yes 2 ☐ No 10e. Street and Number 102 EL BETHEL RD. 10f. Zip Code filed within 72 hours after death with 10g. Citizen of What Country? ROAD 20646 **28086** U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X Xo If Yes, Give Year or Dates: þ 1 ☐ Yes 2 ☐ No Specify: 3℃ Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other SCHOOL TEACHER ELEMENTARY SCHOOLS Maryland 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked ot Be 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE CALDWELL BARBER AMANDA JANE RHEA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health as Important: If item 27 is any injury or other trau GEORGE GOFORTH-SON 6541 HAWKINS GATE RD., LA PLATA, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MET METROPOLITIAN CREMATORY 5-2-05 ALEXANDRIA, VIRGINI 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, PA Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. the motte of dying, such as cardiac or respiratory arrest, 46 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** conges /Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence anding physician and use as the burial-transit Examl Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 mod 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy P.O. 4☐ Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 23e. Did tobacco use contribute to the cause of death? certificate has been sign irector, page 2 should be Completed 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? of Vital 20 No or Attending Physician: 1 Yes 2010 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ဥ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA beind Director; After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; Division 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. To the Hospital or Attend within 24 hours after death To the Funeral Director; , 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) la cestier le 29b. Signature and title of certifier 4.1 29c. License number 29d. Date signed (Month, Day, Year) 2 OS D-0056949 ণ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6620 CRAIN HWY STE 102 LAPLATA, MD 20646

DHMH 17 Rev 1/2001

State Registrar

		State of Maryland / Department of Health and M		ene
		1 - State Registrar Certificate of Death	Re	g. No. 2005 15583
Physic	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
/Medi	cal	Ralph B. Gilmore, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		16,2005 12:20p. ^M
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Hospital Cheverly		4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Georges 9. Birthplace (State or Foreign Country)
Director		577 62 6806 X 58 58 7 5.	8. Date of Birth (Month, Day, 2 / 2 7 / 1 9	947 Wash, D.C.
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Many B-fsh	tor	MD Prince Georges Clinton		1 ☐ Yes 2 ☐ No
ith the or 28	by Funeral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
ath w	ral	8103 Jenni Ave. 20735		U.S.
ter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedent U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 15 Pto)	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
at yiellid A I A I 3-0030 should be filed within 72 hours after death with the Maryland of Mental Hyglene. In marked other then "neturel", or items 23e or 28e-f show matic event, it a Modical Examir er must be notified a		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Specify Black
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed) Flomentary(Secondary (12)) College (1445)	king 1	6b. Kind of Business/Industry
within 9ne.	dmo	Court Complete Control Control	1	M.V.M
filed Hygi other	Be Co	1 Journ	e (First, Middle, M	Sercurity aiden Sumame)
uld be Menta Menta rrked	To B	Ralph B. Gilmore, Sr. Audrey	E. Tho	mas
2 sho and I s me	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rule)	ral Route Number,	City or Town, State, Zip Code)
C, C		Molly Gilmore / Wife 8103 Jenni Ave, Cli	nton, MD	. 20735
ages ant of l		cometery, crematory or other place)		Oc. Location - City or Town, State
pallIIIIOTe, Malyialla ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified an once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		
permi Permi Impo any in		JOIN JOHN JOHN JOHN NO NO NO NO NO NO NO NO NO NO NO NO NO	hn T. Ri	nines,F.H.
		3015 12th ST N 1 23a ant 1. Enter the disease, or complications that cause on each line. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	interval between
Physician /Medical		Imto late Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction		Onset and Death
Examiner		Due to (or as a consequence of):		
P. =	ner	Sequentially list conditions, if any, leading to immediate cause. Either Ungerwing		
ecuted and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
The Colids, F.C. DOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal E	Due to (or as a consequence of):		
oo dificate g phys		d		
th cert ending	M/ue	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
the att	Physician/Med	in the past 12 months? 1		Month Day Year
that the ed by detacl	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
v requires been sign	d by	Hyperlipdemia, Cardiac Arrhythmia	1 ☐ Yes	
aw requires been si	plete		24a. Was an	24b. Were autopsy findings available
OII OI VILAI MEGI ding Physicien: The lav h. After this certificate has funeral director, page 2	Completed		autopsy perform	prior to completion of cause of death? XNo 1 Yes 2 No
OI VITAL Physicien: r this certifica	Be	examiner?	h (Check only one	
Physic rthis or ral dir	- To	1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residen	ce 6 Other (Specify)
nding Ith. :: Afte e fune	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes 2 ☐ No	200. Describe nov	injuly occurred
VISIO Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
rel Div		Suiding, Co. (Specify)		NACHOLOGICA STREET, ST
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cat red at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
ro the vithin of the comple	Mec	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, Day, Year)
->		D0051194	4	/18/2005
L(15)	1	30. Name and address of person who come eted cause of death (Item 23a) (Type, Print)		
		Emerson Cornell, 5001 Silver Hill Rd, Suitlan. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4.	d, MD. 20	746
Sta Regist		Emerson Cornell, 5001 Silver Hill Rd, Suitlan. 31. Date filed (Month, Day, Year) APR 2 6 2005		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Chester L Green 20 2005 April 11:55P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 8. Date of Birth (Month Day, Year) 12/20/1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA **Funeral** Days Hours 1⊠M 2□F Yrs. 227-14-4584 **Director** Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Menla! Hygiene. ortant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic evant, the Medical Examinatment be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery MD Silver Spring Be Completed by Funeral Director 1 XYes 2 □ No 10e. Street and Number 10507 Royal Road 10f. Zip Code 20903 10g. Citizen of What Country? United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistician Department Of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Green Marie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella J Green - Wife 10507 Royal Road Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | 04/30/2005 | Brentwood, MD 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses lleuns 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or or milications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be d Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 Yes 2XNo 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify) $_{Hospice}$ P 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a

To the Funeral E

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) 29b. Signature and title 29d. Dale signed (Month, Day, Year) 29c. License number > 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, MD 6001 Muncaster Mill Rd Rockville, MD 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 5 2005 Registrar

		-	1 - For State Registrar	State of Marylan	d / Departme <i>Certifica</i>			Re	g. No.	5585
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	/Medic	al	Raymond Roy Gr						21,2005	
E	Examin	er	4a. Facility Name (If not institution, give s		4b. C	ity, Town, o	r Location of Death		4c. County of	Death
			104 River Mist		to as blimb do at 1511m	E der 1 Year	1kton If Under 24 Hrs.	1 0 D 1 D: 41	Cec	
	uneral irector		5. Social Security Number 6. Sex 222-66-8944	7. Age (In yrs.	Yrs. Monti		Hours Min.	8. Date of Birth (Month, Day, May 5,	Year) 1966	. Birthplace (State or Foreig Country) PA
fand	Mo ₩		10a. State 10b. County	10c. Cit	y, Town or Location					10d. Inside City Limits
Мал	E 2	호	MD Cecil	E1:	kton					1 ☐ Yes 2 🕱 No
the	r 28e	Director	10e. Street and Number	1 2 2		Zip Code		10	og. Citizen of Wha	at Country?
r Wit	23a o	a D	104 River Mist	Drive		2192	1		U.S.A	1
deat	e de	Funeral		Was Decedent Ever in U Armed Forces?	.S. 13. Was De		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race -	American Indian,
Maryiand 21213-UU30 d 2 should be illed within 72 hours after death with the Maryland th and Mental Hygiene.	ir then "naturel", or iteme 23a or 28e-f show the Medical Examinat rust be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		2 No		moan, etc.)	Specify:	White, etc. White
5-6	natur	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's U	Isual Occup	ation	cina .	16b. Kind of Busin	ness/Industry
within ene.	Mag.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired	during most of work d)	9		
Filed w	1 4	Š	10	- -	Auto M	echai			Automo	otive
De de la la la la la la la la la la la la la	7 is marked othe traumatic event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
aryla should t	is marked raumatic ev	၉	James R. Gree				Patty	Sue B	yrns	
land	is m		19a. Informant's Name/Relationship (Type	,	19b. Mailing Addr	ess (Street	and Number or Rui	al Route Number,	City or Town, Sta	ate, Zip Code)
1 and Health	Item 27 other tr		Tracey Greer/W		104 Ri	ver 1	Mist Dri	ve. El	kton, N	ID 21921
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	lace of Disposition (name or or other plac	(8)	April	20c. Location - Cit	-
Pag men	ury		* 4 □ Donation 5 □ Other (Specify)	NOT	ttingham	Miss	sionary	27.2005	Notti	ngham,PA
Balt permit. Departr	Importent: If I any injury or once.		21. Signature of Tuneral Service License	e Daj			Gee Fu			
ه م	i E e d		23a. Part1. Enterthe disease, or complishock, or heart failure. List only on	e cause on each line.	h. Do not enter the n	East node of dyin	Main St	or respiratory arre	ton, ME	Onset and Death
/M	sician ledical aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	NETTIC		ALC	-1		8 Maths
nted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Little for industrying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
. BOX 68/60, death certificate be executed	hysician and he burial-transit	dicai Exe	resulting in death) Last	Due to (or as a conseq	juence of):					
BOX 68	ding p	n/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		c pregnancy			23d. Date o	of delivery
	by the atter stached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown					Month	Day Year
ecords, P.O law requires that the	pe de	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause giv	en in Part I.			ute to the cause of death?
j ş	should	lete						24a. Was ar	24h We	re autopsy findings availabl
T e	cate has , page 2	Completed						autops	y prio	r to completion of cause of
of Vita Physicien:	certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		th (Check only on-	e)	
Phys	this aldi	ဥ	1 Yes 2 No	1 Inpatient 2		DOA Oth	4 Nursing H	ome 5 Reside		() //
VISION Attending I	After	ation	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injur Wor 1 🗌	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVIS tal or Att		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, office		28f. Location (St. City or Town		or Rural Route Number,
he Hospital	To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examile one)	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death occur ation and/or investigat	red at the tir ion, in my o	me, date and place, pinion, death occur	and due to the carred at the time, da	use(s) and manne ate and place, and	er as stated. If due to the cause(s)
To the	To t	ž	29b. Signature and hijh of certifier	1	1	29c. Licens				Month, Day, Year)
1	,		30. Nam and address of person who co	mpleted cause of death (Iter	m 23a) (Type, Print)		0002 70		4/22	101
(0		3/3 West Main	Street N	PEWACK	DE	19711	,		
	Sta	ate	31. Date filed (Month, Day, Year) APR 9 5 2005	32. Registrar's Signa	ature frank !					

		1 - State O		rtment of Health and M tificate of Death		ene 1. No. 005	15586
Physici		Decedent's Name (First, Middle, Last) DOREEN IVY GRE	3		2. Date of Death	Day Year 4, 2005	3. Time of Death 8:15 AMM
/Medio Examir		4a. Facility Name (If not institution, give street and nur WESTMINSTER NURSING/CON		4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director		5. Social Security Number 6. Sex 1 M 2004	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4,1919 EN	place (State or Foreign ofto) GLAND
Maryland a-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CARROLL	10c. City, Town or Low WESTMINS				10d. Inside City Limits 1 ∐Yes 2 【️️️️️️
with the	Directo	10e. Street and Number 2167 SYKESVILLE ROAD		10f. Zip Code 21157		g. Citizen of What Cou	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked other than "hatural", or Itams 23e or 28e-f show unafte event, the Medical Exerting must be notified at	by Funeral		2√0 000 1	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes XXNo Specify:		14. Race - Ameri Black, White	can Indian,
be filed within 72 hours ntal Hygiene. so other then "natural", event, the Medical Exe	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1)	16a. Deced (Give /ife. L	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Ir	ndustry
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental to a market the mental control of the Me	Be	12 17. Father's Name (First, Middle, Last) MTLSTED-8			e (First, Middle, Ma		ric
2, 73 90 27	2	19a. Informant's Name/Relationship (Type, Print) PAT WALSTRUM-MCINERNEY/DA	19b. Mailin	g Address (Street and Number or Run SYKESVILLE ROAD,	al Route Number, (City or Town, State, Zi	o Code) 21157
8,2=5		20a. Method of Disposition 1 Burial XX Cremation 3 Removal from 4 Donation 5 Other (Specify)	20b. Place of Dispo	sition (Name of natory or other place)	Date 20	Oc. Location - City or T	own, State
permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licenses	MY 91	Name and Address of Facility ERS-DURBORAW FUNE WILLIS STREET, W	RAL HOME,	, P.A. ER. MD 2	1157
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	each line.	er the mode of dying, such as cardiac en acculent ata Vasculu aza			Approximate Interval Between Onset and Death
ne death certificate the attending phy:	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, our 1 Live to	tcome of pregnancy irth 2 Fetal death 3 nant at time of death 5	Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
quires that the signed by	by	Part II. Other significant conditions contributing to d	eath but not resulting in the ur	derlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	he cause of death?
The law requir ate has been s page 2 should	ompieted				24a. Whas an autopsy performe	prior to co	opsy findings available empletion of cause of
siclan: The law s certificate has t director, page 2 s	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ☐ ER/Outpatien	Other	h (Check only one)	ce 6 □Other (Specia	(v)
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate h: completely filled in by the tuneral director, page	ertification; T	27. Manner of Death 1 Natural 5 Pending (Mon 2 Accident investigation			28d. Describe how		77
To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the t	0	4 Homicide build	of Injury - At home, farm, streng, etc. (Specify)		City or Town,		
To the Hospital or Atwithin 24 hours after d To the Funeral Direct	Medical	(Check only 2 Medicel Examiner: On the bone) and man	best of my knowledge, death asis of examination and/or inv ner stated.	restigation, in my opinion, death occur	red at the time, date	e and place, and due t	o the cause(s)
MAL	N	29b. Signature and title of certifier July W. Mydd	lita MD	29c. License number D 25443	290	1. Date signed (Month),	-005
- CA	ate-	John W. Middleton. 31. Date filed (Month, Day, Year) 32. F	se of death (Item 23a) (Type, in the second	o Road, West	Am 175tes	g mo	21157
St Regist DHMH 17 Rev 1/2	rar	APR 2 5 2005	tran & A	laste		•	•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Irene B. Gue April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mount Airy

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Min. | Tan 0 1920 Carrol1 2500 Flag Marsh Rd. 7. Age (In vrs. last birthday. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 14 F 85 219-01-9749 A Director Jan 9, 1920 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 2500 Flag Marsh Rd. 21771 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 7th Clerk Geico Insurance peji 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h Ollie Porter Mammie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: # Item 27 Is m any injury or other traum Nancy A. Seals (Daughter) 2500 Flag Marsh Rd. Mt. Airy, MD 21771 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Poplar Springs Cem 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2005 Poplar Springs, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.

Rd. Winfield. MD 21784 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardrophyo pathy **Physician** 24ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hyperfension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year signed by the aid be detached for 5 Other (specify) 1 ☐ Yes 2 XNo P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 should be 3 ☐ Probably 4 ☐ Unknown 1□ Yes 2□No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 52035 NO WI 30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print) 4 HALLO Store 31. Date filed (Month, Day, Year) 32. Regietrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 15588 State Registra AMEND ITEM #19a PER FH G843 99 Per if in a top to the state of the s Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:00 Edna Elizabeth April 30 2005 Hoy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Skyway Manor Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 TF 96 VA March 22, 1909 Director 577-32-1034 Usual Residence of Decedent 10c. City, Town or Location ahow 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or liema 23a or 28a-1 ahow traumatic event, the Madical Examina must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel **Annapolis** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 1142 Skyway Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yas Give Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ernest Graham Beard Rachel Middleton 2 of Health and No. 11em 27 is mail other traumer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER Sister Margaret Cain -19365 Cypress Ridge Terr #710 Lansdowne VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department I Important: If any injury or 05/04/2005 Chestnut Grove Cem. Herndon, VA ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Adams-Green Funeral Home 721 Elden St., Herndon, VA 20170 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final advanced denent'a **Physician** reavs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No squelve has 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS ISTER Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 2 Accident 5 Pending 1 Tyes 2 No death. investigation in by the f within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 100 29c. License number 29b. Signature and title of certifie 10 State Registrar

				partment of Health and Men	tal Hygier		15589
	Physicia	212	Decedent's Name (First, Middle, Last)		Date of Death Month	ay Year	3. Time of Death
	/Medic		JOSEPH K. HATCHETT		pril 22,	-	12:10 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK		MONTGOM	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 12 M 2 F 7. Age (In yrs. last birthda) 7. Age (In yrs. last bi	Months Days Hours Min. (/	Date of Birth Month, Day, Yea		lace (State or Foreign try)
	Director		Usual Residence of Decedent	Feb	bruary 2	8, 1920	Danville,
	ow ow		10a. State 10b. County 10c. City, Town or t	ocation		1	0d. Inside City Limits
	Mary Fish	to	Md Montgomery Sil	ver Spring			1√∑Yes 2 No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	try?
	h with	Funeral Director	2315 Glenallen Ave., #102	20906	T.	nited Sta	tac
	deat	ner		. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar		14. Race - Americ Black, White,	an Indian,
98	or Items	F	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	11, 010.)	Specify:	eic.
21215-0036	72 hours after death with the Maryland natural', or ltems 23a or 28a-1 show Jical Exscrimer must be notified at	d by	3 Vidowed 4 □ Divorced Year or Dates:	**		B1	ack
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Inc	dustry
12	within ene. then *	m d	Elementary/Secondary (0-12) College (1-4or 5+)				
9	filed Hygir ther ant, t		6th 17. Father's Name (First, Middle, Last)	Maintenance 18. Mother's Name (Firs	st. Middle, Maide	Private	
an	ld be ental ked o	To Be	Frank Hatchett	Esther All		,	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, it e M	Ĕ		ling Address (Street and Number or Rural Rou		or Town. State. Zin	Code)
Z	nd 2 :			5 Glenallen Ave., #10			
ľe,	s 1 and Health Item 27 othar tr		20a. Method of Disposition 20b. Place of Disp	position (Name of Date		Location - City or To	
30	Pages nent of I int: If it		1 LX Burial 2 Cremation 3 Chemoval from State	ematory or other place) ncoln Cemetery 4-28-0	15 P	rontrood	MJ
altimore,	그 든 뿐 글			22. Name and Address of Facility		rentwood, ol Mortua	
ä	permi Depa Impo any ir		Major John Jally 1	425 Maryland Ave., N.	E. Wash		
			23a. Part1. Enter the disease, of complications that caused the death. Do not enspock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or res	spiratory arrest,	, , , , , ,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	3 Failure			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				
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	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,			
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	19			
50,	oe ex		Dueno (or as a consequence of):				
8760	death certificate be executed e attending physician and id for use as the burial-transit	edicai	d				
9 X	leath certifica attending pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			O2d Date of delice	
Вох	atten for u	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Day Year
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Δ.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
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of Vital Records,	w requires that s been signed b should be det	Completed		3	24a. Was an	24b. Were autor	osy findings available
Re	The law cate has b page 2 st	mc			autopsy performed?	prior to con death?	apletion of cause of
tal		a	25. Was case reterred to medical	26. Place of Death (Che	1 Yes 2	1 ☐ Yes	2 No
>	Physician: this certificant	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor		6 □Other (Specify)
0	g Phys er this ieral di		27. Manner of Death 28a. Date of Injury 28b. Time		Describe how in		,
0	Attanding F r death. ector: After by the funer	atio	1	M 1 Yes 2 No			
Division	er de er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. L	Location (Street of	and Number or Rurai	Route Number,
۵	talon rs aft al Di	Certification:			,		
	Hospital or 24 hours afte Funeral Dir tely filled in I	edical	29a. Certifier (Check only (Ch	th occurred at the time, date and place, and d	due to the cause	(s) and manner as sta	ated.
	To the Hospital or Attanding Phwitin 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral		one) and manner stated.				``
	witl To	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, L	Day, Year)
•			1 /VLY VASTE	DHIYT	/	TIdo	4/15
	(5)		30, Name and address of person who completed cause of death (Item 23a) (Type	Print) Woshing	Gton	Adves	AST HAZ
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature	V	1 1011	0 (0)	100
	Registr	ar	APR 2 6 2005	W.			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6:32 f M orraine 005 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Douthern Mar land Trince Tospita reorges Moton 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 577-46-8788 May Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show other treumetic event, the Medical Examiner must be notified at Ma 1 Yes 2 No Director Georges 15tr101 rince 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20747 anow or Items 23e Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 100 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black δ 3 ₩idowed 4 Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) omemaker d 2 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permil. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked it any injury or other treumetto eve Unknown 2 lar 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atricia U alter Pàul 20743 Fairment 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Surtland * 4 ☐ Donation 5 ☐ Other (Specify) Memorial 23. Name and Address of Facility
Ralph Williams Fun
1813 Potomac Ave. SE of Funeral Service Licensee D.C. 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) n signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ⊡ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 -No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death Check on one examiner? Hospital: Other: 2 1 ☐ Yes 2 ☐ 110 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1 Natural 5 Pending Hospitel or Attendin 24 hours after death. Funerel Director: Aft М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) complited cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	aryland		artment tificate			nd M		giene Reg. No.	05	155	9
	Physici /Medic		Decedent's Name (First, Middle, Last,	CORA LO	OUISE	HAL	TER				2. Date of Dea Month APRTL	Day	Year 2005	3. Time o	M
	Examin		4a. Facility Name (If not institution, give	TAL CENT	ER		WE	STM	Location o	ER		4c. C	ounty of Death	L	
	Funeral Director		5. Social Security Number 220-03-8446 Usual Residence of Decedent	x 7. Ag]M 2∏ F	ge (In yrs. Ias 85	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 1/26/	y, Year)	Co	nplace (State untry) YLAND	
	Maryland s-f show	tor	10a. State 10b. County CARROLI			Town or Lo		ER						10d. Inside 0	City Limits
	with the a or 28s	Director	10e. Street and Number	3.DE 6	0.0		10f. Zip						n of What Co	untry?	
920	d within 72 hours after death with the Maryland Jiene, rthan "natural", or Items 23a or 28a-1 show Itte Macifiel Examination and Demodified at	by Funeral	30 LOCUST ST., 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig , Mexican	gin? (Spe , Puerto I	ecify Yes or No Rican, etc.)		Race - Amer Black, White		
21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or		life.	dent's Usua kind of wor DO NOT us HINE	k done d e retired)	uring most		ng		of Business/I JFACTU	-	
Maryland 2	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) MII	LTON		HALTI			S	USA			MAUS		
	27		19a. Informant's Name/Relationship (T)	урв, Print) — NIEC	E	931	ROLL	ING		GE D	Route Numbe	STMI	NSTER	, MD.	1157
Baltimore,	0 0		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		ST. I		S CE	ther place EMET		4/2		SILV	ER RU	N, MD	
Baj	permit. Pag Department Important: I any injury o		21. Signatul of June I Service Livers	99		8.1					ETCHER WESTMI				57
	Physician /Medical		23a. Part1. Enfor the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	d the death. ine.						respiratory and		la.	Approxima Interval Be Onset and	neewte
8760,	cate be executed : physician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		ence of):	u c	Co	vdi	8 D	Serve	en di	Bege	work	y
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal c	leath 3	Ectopic pro					23	d. Date of deli Month	very Day	Year
<u>α</u>	w requires that been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death t	but not result	ting in the u	nderlying co	ause give	n in Part I.		23e. Did t		contribute to	the cause of	
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of	ding Physician: n. After this certific funeral director,	To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inju		R/Outpatier 28b. Time o Injury		8c. Injury Work	r: 4 □ Nu at	rsing Hor	me 5 Residence	dence 6		ify)	
Division	I or Attendi after death. Director: A d in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At hom tc. (Specify)	ne, farm, sti				_	28f. Location (City or To	Street and a	Number or Ru	ral Route Nui	mber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis of and manner si	t of my know of examinatio tated.	ledge, deat on and/or in	h occurred vestigation.	at the tim , in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause	(s)
	Multhir To th	Me	29b. Certifier (Check only one) 29b. Signatur III title of certifier 30. Name and address of person who certified (Month, Day, Year) APR 2 1	u mage	arre		290	. License	number	00		29d. Date	signed (Month	o, Day, Year)	
_	2		30. Name and address of person who co	death (Item :	23a) (Type.	Print)	ole	Rd	Wa	Moon!	ntes	MI	211	57	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 1	2005 32. Regin	har's Signatu	en de	Some	رع							

Carole Frances Hankins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 02793State of Maryland / Department of Health and Mental Hygiene RPD 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CAROLE FRANCES HANKINS April 0849 a 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 💢 F 58 Director Jan. 25, 1947 California 219-46**-**5575 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland Prince George's <u>Landover Hills</u> the 10e. Street and Number 10g. Citizen of What Country? 4416 71st Avenue 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates: ģ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Manager s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is markad other th 1+ University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Joseph Breidecker 2 Helen Erma Langford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 19a. Informant's Name/Relationship (Type, Print) Health Item 27 Carole Hankins - Daughter 9815 Stephen-Decatur Highway #9, Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) 4/28/2005 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funejal Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. as 4739 Baltimore Ave., Hyattsville, MD 20781 Tons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Multiple Injuries resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examine physiclen and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 □ No detached Records, P.O. 9 DUnknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 X Yes 1X Yes 2 No 2 No Division of Vital Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 5 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: or Attending 5 Pending investigation Driver of truck struck by 1 Natural death. 2 X Accident 4-21-05 7:59 a M 1 ☐ Yes 2 X No Director: another vehicle 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Rt 450 & 4 Homicide after Veteran's Pkwy, Hyattsville, Highway To the Hospitel within 24 hours a To the Funerel Completely filled. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifle OCME April 25, 2005 9 30. Name and address of person who co-hilleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 2 5 2005 com & specie Registrar

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is certific director,		27. Manner of Death	28a. Date of In (Month, D	jury 28b. Tin Day Year) Inju		28c. Injury Work	at	280	d. Describe ho	w injury occur	red	
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Examin	er	4a. Facility Name (If not institution, gi	_			Town, or Location of Deat	th		County of Dea	
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Maryla f sho	ō	Tou. State								1 Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Iteme 23e or 28e-f show any injury or other treumetto event, Ire Medical Examiner must be notified at ODGe.	Director	Maryland Montgom 10e. Street and Number	ery	Silver	Spring 10f. Zi			10g. Citi;	zen of What Co	ountry?
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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Phyeician: The law requires that the death certificate be executed

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Kshama Gang, M.D. 1500 Forest Glen Road Silver Spring, Maryland

APR 2 5 2005

Kshama Gang

29c. License number

D60826

29d. Date signed (Month, Day, Year)

April 22, 2005

20910

			Please	Type or Print in I				-	_	
			For State Registrar	State of Marylar	•	tificate of		Reg. I	2005	15595
	Physici /Medic		1. Decedent's Name (First, Middle, La	Louis		Jone.	5	2. Date of Death Month April 28	Day Year	
	Examir	er	4a. Facility Name (If not institution, giv		,	40	or Location of Death		4c. County of Dea	4
			Dorchester Gener			Cambr			Dorche	
П	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday).	Months Days		8. Date of Birth (Month, Day, Yea	9. Bir	rthplace (State or Foreign country)
	D.		Usual Residence of Decedent					001, 3, 1 1	A 3 1 4 7 1	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Exams are must be rediffied at	ŭ	10a. State 10b. County	1	ity, Town or Lo	1				10d. Inside City Limits 1 ☑ Yes 2 ☑ No
5	the N	ect	MD DORCH	ester	Can	1 by i do	je	100.0	Citizen of What C	
4	3a or	Funeral Director	701-Race.	Street ADL	114	2	1613	1.09.	11 < 4)
7	death ms 2	nera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	14. Race - Am	erican Indian,
9	after or Ite		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Tes, specify Cul		o Hican, etc.)	Black, Whi	
5-0036	ural',	db	3 Widowed 4 Divorced	Year or Dates:					Specify: 3	lack
15-	n 72 n "nat	Completed by	15. Decedent's E (Specify only highest gra	ade completed)	(Give	lent's Usual Occu kind of work done DO NOT use retin	during most of wor	king 16b.	Kind of Business	s/Industry
2121	filed within Hygiene. other than " ent, the Med	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	0		ine Wo	rker F	vazen	Foods
	be filed tal Hygie d other event,	BeC	17. Father's Name (First, Middle, Last)			1	ne (First, Middle, Maid	en Sumame)	
Maryland	should be and Mental is marked o	To	UNKNOWN)			un	Known		
Nar	2 sho		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree	and Number or Ru	ral Route Number, Cit	y or Town, State,	
	1 and Health em 27		20a. Method of Disposition	-Sey 20h 1	Place of Dispo-	M Wood sition (Name of	HIVE, HPT		range,	N. J. 07018
Baltimore,	0 0		1 🖺 Burial 2 🗹 Cremation 3 🗆	Removal from State	cemetery, cren	natory or other pla		a literary		AM. / . /
ij			4 □ Donation 5 □ Other (Special21. Signatore of Funeral Service Lices		d Shor	e ('rema	tion 4/2	8/05 00	ambrid	e, Maryland
Ba	permit. Departn Imports any inju		Danelle (2. Stewer	H	ENRY FU	ess of Facility	St. Cambr	: das 1	1D 21613
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H	Physician		Immediate Cause (Final disease or condition	Coloponh	0 4	2002 :	Fullin	1.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	w /	LCC (OV)			10 years
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Вох	th cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnan	cy		23d. Date of de	
	the at	/sici	1 Yes 2 No	4☐Pregnant at time of o		Other (specify)	-		Month	Day Year
P.0	that the de ned by the a detached t		Part II. Other significant conditions	contributing to death but not re.	sulting in the ur	nderlying cause d	Iven in Part I	23e. Did tobacc	o use contribute (to the cause of death?
Records,	uires tha signed I Id be det	d by	•	3	, , , , , , , , , , , , , , , , , , ,			1 ☐ Yes		frobably 4 □Unknown
COL	w require been sign	Completed						24a. Was an	24h Were a	utopsy findings available
Re	siclan: The law s certificate has t irector, page 2 s	ошо						autopsy performed	prior to death?	completion of cause of
Vital	10	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one)	No 1 ☐ Ye	s 20 No
of V	Physiclan: this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpatien	t 3 DOA C	ther: 4 🗌 Nursing H	ome 5 Residence	6 ☐Other (Spi	ecify)
	ding Pl After th funeral		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describe how in	jury occurred	
sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	00]Yes 2 □No			
Division	after of Direction by	Certification:	4 Homicide determined			eet, factory, office)	28f. Location (Street City or Town, St.		Rural Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Exa	hysician: To the best of my kn	owledge, death	occurred at the	time, date and place	, and due to the cause	(s) and manner a	s stated.
	the H hin 24 the F nplete	Medical	one)	miner: On the basis of examination and manner stated.	ation and/or in	-				
	with To	2	29b. Signature and title of certifier	1. 1.	1	29c. Licer	nse number	29d. I	Date signed (Mon	nth, Day, Year)
			Mucheli	Hr. 4/22	105	01	1341.	4	722/03)
			30. Name and address of person who Vinodrai Mehta 4				ryland 21	613		
	St	ate	21 Date filed (Manth Care Vees)	32 Registrar's Sign	ature		-			
	Regist		71 1 6 6 6	JUJ Gree .	In the	sort u				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gladys Elvira Kinna May 2, 2005 9:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Make 12 Day (Year) 1912 7. Age (In yrs. last birthday) 93 Yrs. Birthplace (State or Foreign Marry Land 5. Social Security Number 217-28-7445 **Funeral** 1 □ M 2 □ F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, Ite Nedical Exact it at mark to notified at Frederick Braddock Heights 1 X Yes 2 ☐ No Director Maryland 10e. Street and Number 6012 Jefferson Blvd. 10f. Zip Code 10g. Citizen of What Country? 21714 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Z☐ No Specify: þ Specify: 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Tailoring Company 6 permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Importent: If item 27 is marked othi any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elmer Dixon Olivia Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolly Mae Smith/Daughter 274 Pinoak Lane, Frederick, Maryland 21701 Method of Disposition

20b. Place of Disposition (Name of comment 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Keeney and Basford Funeral Home Signature of Funeral Service Licensee M00021 alleral 106 Fast Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis hus /Medical Due to (or as a consequence of): **Examiner** neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (as a consequence of) The law requires that the death certificate be executed Unkuwn winding frac Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Live birth 2 Fetal death for Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page certificate ! 1 Yes ZNo Hospitsl or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No Certification: To 2 ER/Outpatient 3FT DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 4th, 2005 D47169 run 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 9+HAVE BRUNSWICK, MD21716 CHANHONG TO, M.D Registrar's Signature 0 9 2005 State Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, I	State of Maryland		artment of tificate o		nd Mental Hy	Reg. No.	005	Time of Death
	Physici /Medic Examin	al	JUNG JA 4a. Facility Name (If not institution, g HOLY CROSS	KIM ive street and number) HOSPITAL		4b. City, Town	o, or Location of DER SPF	APRI:	4c. Cour	Year	7:46P M
	Funeral Director		5. Social Security Number 215 29 8312 Usual Residence of Decedent	Sex 1 M 2 F 7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Ye Months Day		Min. B. Date of Bi	rth ay, Year) 1933	9. Birthplace County) SOUT I	(State or Foreign H KOREA
ore, Maryland 21215-0036	jes 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other then "natural", or Itema 23a or 28a-f show or other traumatic event, the Modical Extrained must be confilled at	To Be Completed by Funeral Director	10a. State MD MONTG 10e. Street and Number 20300 ROSET 11. Marital Status 1 Never Married (Specify only highest of the state) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, La BONG BONG O KIM 19a. Informant's Name/Relationship	OMERY GA HORN AVE 12. Was Decedent Ever in U.S. Armed Forces? 1	16a. Deceder (Give Info. Leave of Dispose of	RSBURG 10f. Zip Code 208 Was Decedent of Yes, specify C I Yes 2 X N Jent's Usual Occ kind of work doi OO NOT use ref	of Hispanic Origin uban, Mexican, File Specify: Coupation re during most original) 18. Mother's NAP Pet and Number of THORN	Name (First, Middle SOON or Rural Route Numb	KOR 14. R 8 Special 16b. Kind of PRIV Maiden Sum KIM Per, City or Tow	of What Country? EA ace - American In lack, White, etc. city: ASIA Business/Industry (ATE ame)	AN (20882
8/60, Baltim	ate be executed with the burial-transit and burial-	dicai Examiner	`4 □ Donation 5 □ Other (Spe	anse NO	22 1 2 . Do not enter ence of):	X MEMOF Name and Add 303 KF ar the mode of d	dress of Facility	4/26/05 CHARLES UPPER	MARLB	FUNERA ORO MD	AL SERV. 20772 roximate rval Between et and Death
ds, P.O. Box o	es that the death certif igned by the attending be detached for use a	d by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal (4 Pregnant at time of de 9 Unknown contributing to death but not resul	death 3□ ath 5□	Ectopic pregnal Other (specify) aderlying cause		111	N	Date of delivery Month Day Intribute to the cau 3 Probably	
or Vital Rec	hysiclan: The law this certificate has al director, page 2 (n: To Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No 27. Manner of Death		R/Outpatient	t 3 DOA	Other: 4 Nursi	24a. Was	an psy 24b primed? 2 XNo one) dence 6 00	b. Were autopsy fil prior to completi death? 1 Yes 2 I	ndings available ion of cause of
DIVISION	To the Hospital or Attanding P within 24 hours efter death. To tha Funeral Director: After i completely filled in by the funers	cal Certification;	1 Natural 5 Pending investigat 3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only 2 Medical Ex	(Month, Day Year) be d 28e. Place of Injury - At hor building, etc. (Specify) Physician: To the best of my know	Injury ne, farm, stre	eet, factory, office	Yes 2 No	28f. Location (City or To	Street and Nur wn, State)	nber or Rural Rou	
	To the Ho within 24 To the Fu Completel	Medic	29b. Signature for the of certifier 30. Name and address of person wh	and manner stated.	on and/or inv	29c. Lice	y opinion, death on one number 2332	occurred at the time,	date and place 29d. Date sign	e, and due to the coned (Month, Day, 1)	Year)
	Sta Registr		SK GUPTA, MD 31. Date filed (Month, Day, Year) APR 2 5 20	9801 GEORGIA	A AV	E STE	220 SI	LVER SP	RING I	MD 2090	2

			For State Registrar		Maryland		rtment tificate			and M	R	eg. No. 200	5 1559
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Š,	Funeral		MONTGOMERY 5. Social Security Number		HOSPIT		If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreigr Country)
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	r 28a-f sh	Director	MD MONTO	GOMERY	BUR	RTONS	VILL:				1	0g. Citizen of Wha	1 X Yes 2 □ No t Country?
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	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f show ta Madral Examinar must be motilled at	b	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes If Yes, Give Year or Da	2 Mo e tes:		1□Yes 2	No No	Specify:		, noari, etc.,	Specify:	ASIAN
21213-000	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural, or Itema 23a or 28a-1 show event, the Medical Examinational Landilled at	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)			life. I	lent's Usua kind of wor DO NOT us SEKE	k done d e retired)	uring mos	t of worki	ing	16b. Kind of Busin	,
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, mai yianu	d 2 s th ar 7 Is trau		19a. Informant's Name/Relations		(WA.		ng Address WAT					r, City or Town, Sta ONSVILLE	te, Zip Code) E MD 20866
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	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (c	aused the death. ach line.	ence of):					diseas.		Approximate Interval Between Onset and Death
שמי מפן מחם	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	come of pregnanth 2 Fetal o	cy death 3	Dectopic pro					23d. Date o	f delivery Day Year
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necolus,	e law has b	Completed t									1 □ Y 24a. Was a autor	an 24b. Wer sy prior med? deal	☐ Probably 4 ☐ Inknown re autopsy findings available r to completion of cause of th? Yes 2 ☐ No
DIVISION OF VIIA	ding Phyaician: h. After this certific funeral director.	ertification; To Be (3 ☐ Suicide 6 ☐ Could	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		P/Outpatier 28b. Time o Injury	f 2 M	8c. Injury Work 1 🔲 `	er: 4 □ Nu	ursing Ho	28d. Describe h	ence 6 Other (Specify) or Rural Route Number.
2	i Dir	O	(Check only 2 Medical	ng Physician: To the Examiner: On the ba	best of my know	rledge, deat	h осси пе d	at the tim		nd place,	City or Tow	n, State) ause(s) and manne	er as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29b. Signature and title of certific	and mann	Med Dir E							29d. Date signed (A	
1	St.	ate	30. Name and address of person 10. hae 31. Date filed (Month, Day, Year	MD M2. R	e or geath (Item	y General	est fa	bspila	I,	olne	CIM P		
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orraine Lowther

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ovaluet)5 2005 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Center Westminster DUVOL 110140 If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1□M 2XIF Months 73 216-30-1273 Director Jan. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 le marked other then "naturel", or Items 23a or 28a-f show ary or other traumatic event, if a Medical Exercitive round be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Maryland Carroll County Director Westminster 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 Stone Road 21158 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 11 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Rodkey Miriam Unger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald M. Leister / husband 708 Stone Road Westminster, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 6. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Tyrone, Maryland permit. Page Department of Importent: If any injury or once. Baust Church Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 2005 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licensee 136 East Baltimore Street Taneytown, Md. 21787 unr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician FIBRILLATION ENTRULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** (ARD) LINFARCTION Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the IF FEMALE: Box nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 \ No Vital 2 **N**o 1 Yes 1 Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 Yes 2 No 2 PA/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division the Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director; 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) D 0018200 NACIANNA MD. 700-A POOLE Rd. WESTMINSTER MD 21157

Registrar

State

DHMH 17 Rev 1/2001

30. Name and address of person who completed causs of death (Item 23a) (Type, Print)

32. Rasistrar's Signature

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MAY 0 9

31. Date filed (Month,

			For State	State of N	Maryland / Depa	artment of H			2005	15601
			Registrar 1. Decedent's Name (First, Middle,	Last)	Cei	illicate of t	Dealli	Reg	Noi- UU	3. Time of Death
	Physicia		Jaime Rafael					Month	Day Year	м
	/Medic Examin		4a. Facility Name (If not institution,		er)	4b. City, Town, or	Location of Deat	April 2	3 2005 4c. County of Dea	2:10pm "
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	Funeral			6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		Montgome 9. Bi	rthplace (State or Foreign country)
	Director		136-07-3511	1∰M 2□F	92 Yrs.	Months Days	Hours Min.	(Month, Day, Y May 29.		ountry)
	p ,		Usual Residence of Decedent		10.00					
	shov	ř	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	ith the Marylan or 28a-f show	Director	Maryland Montgo	mery	Silver Sp					
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2	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene "neturel", or Items 23a or 28a-f show dother then "neturel", or Items 23a or 28a-f show event, Ital Madical Exerciter most be notified at	Be	17. Father's Name (First, Middle, L				18. Mother's Nar	me (First, Middle, Ma	iden Sumame)	
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ō	2 sh and Is m		19a. Informant's Name/Relationsh	, , ,	19b. Mailii	ng Address (Street a	and Number or Ru	ural Route Number, C	ity or Town, State,	Zip Code)
= 15	1 and Health em 27 ther tr		Barbara Dillon/	daughter	2312	Cranberry		, Silver		
5	Pages I		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from Sta	20b. Place of Dispo cemetery, crei	natory or other plac	e) Ap	ril 27,	c. Location - City of	r Town, State
			`4 □Donation 5 □ Other (Sp			wn Cremat		2005 Pa	atterson,	NJ
0	permit. Depentilimporte any nje		21. Signature of Funeral Service L	Jicensee						neral Home,
			23a. Part 1. Inter the disease, or o	Ucely .						ng, MD 20901
	nes menos mos		shock, of heart failure. List of	only one cause on each	n line.	er the mode of dyln	g, such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death
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א מ	h cer endir	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		Ectopic pregnancy			23d. Date of de	olivery
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ń	The law requires that the death certific ste has been signed by the attending p age 2 should be detached for use as:	by	Part II. Other significant condition	ns contributing to deat	h but not resulting in the u	nderlying cause give	en in Part I,			to the cause of death?
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	spitel ours nerel lilled	O	29a. Certifier 11 Certifying	Physicien: To the be	est of my knowledge, deat	h occurred at the tim	ne date and place	and due to the caus	ro(e) and manner a	e stated
	To the Hospitel or Attending Physiclem: within 24 hours after death. To the Funerel Director: After this certific completely lilled in by the funeral director,	edical	(Check only 2 Medicef E	Exeminer: On the basis and manner	s of examination and/or in	vestigation, in my or	pinion, death occu	irred at the time, date	and place, and du	e to the cause(s)
	To th within Fo th compl	Me	29b. Signature and title of certifier			29c. License	e number	29d	Date signed (Mon	th, Day, Year)
			Chilie by	larga el		D424	152			
	5+1		30. Name and address of person v	vhg completed cause of	of death (Item 23a) (Type,	Print)		Ar	ril_23,	2005
_			Chitra Rajagopa	1. MD 600	1 Muncaster		d. Rocky	ille. Mn 🤉	0855	
	Sta		31. Date filed (Month, Day, Year)	32 Regi	strar's Signature	. N. D	, 1,000		and the special section is a second	
	Registr	rar	APR 25	2005	W 15. 1400					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Katherine K. Leibold April 21 2005 4:50 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🖫 F 91 Yrs. Director 579-01-3733 Washington, DC August 27,1913 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or githar traumatic avant, Ite Medical Evantment. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Silver Spring Maryland Montgomery 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 International Blvd. 20906 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas S. Kennedy Blanche Steckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Kuberski/Daughter 241 Witch Duck Lane, Heathsville, VA 22473 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University April 1 Burial 2 Cremation 3 Removal from State 2005 ' 4 Donation 5 ☐ Other (Specify) Medićal Center Washington, D.C. 21. Ignatur V f Funeral Strvice Lice 22. Name and Address of Facility Columbia Mortuary Services, P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNSTROINTESTINAL **Physician** HEMORPHAUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 1 🗌 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred : After Certification: 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 Accident tha Funaral Diractor: in by the 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 To the Fu 29b. Signature and title of 29c. License number person who completed cause of death (Item 23a) (Type, Print) MERMATIONAL DR #211, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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	Physicia	an	1. Decedent's Name (First, Middle	, Last)	T LIP §	30 4 3_370	MUJ	JH			2. Date of De	eath	- 000	3. Time o	
	/Medic Examin	al	AUTUMN ME 4a. Facility Name (If not institution U.S. 70		mber)		4b. City,		Location (of Death	APRTI.	4c.	, 2005 County of Dea ASHINGT		Ам
	Funeral Director		5. Social Security Number 235 - 27 - 4608	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yi	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT. 9	rth ay, Year) , 198	9. Bir WEST	thplace (State of puntry) VIRGINI	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD WA	SHINGTON	10c.	City, Town or Lo	ocation GERST	.OMN						10d. Inside C	ity Limits
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336	urs after dea it', or ttems	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo ied 1 Yes If Yes, Gin Year or D	orcews? 2 ☐ No	1	Was Deced If Yes, spec 1 ☐ Yes		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify:		-
1215-00	permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 27 is marked other than "naturel," or items 23a or 28e-f show any injury or other traumatic event, it a Medical Examiltant, and by notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed)	1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d e retired	during mos i)	st of worki	ng		nd of Business Y MORT(COMPAN'	GAGE	
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, Mary	and 2 sho salth and N n 27 is ma		19a. Informant's Name/Relations DOMINGO MENDOZ			60 N	1ANOR	DR.	APT.	er or Rura 104	, HAGE	per, City o RSTOW	IN, MD	Zip Code) 21740	
timore	E Pages 1 tment of Hi tent: if iten jury or oth		20a. Method of Disposition 1 Deurial 2 □ Cremation 1 Donation 5 □ Other (S	pecify)	State	o. Place of Dispo cemetery, cre. OSEDALE C	matory or o	ther plac	(a) N	1AY 3, 2005	Date	20c. Lo	MARTII	Town, State	WV
Bal	permit Deper Impor any in		21. Signature of Funeral Service Will 12 23a. Part1. Enter the disease, or	- Bion		2	ROWN	FUN 327	ERAL W. K				821 ISBORG,	WV 254	
8760,	/Medical pe executed hysician and principle pr	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to b Due to	(or as a cons	sequence of):	LS OR		g, 30011 au		, lospitude y c			Approximal Interval Bet Onset and	ween
Вох 6	Physicien: The law requires that the death certificath is certificate has been signed by the attending plant director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. yes 2 No		oirth 2 ☐ F nant at time o	etal death 3[⊒Ectopic pr ⊒ Other (sp		,				23d. Date of de Month		Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant condition	ons contributing to d	eath but not	resulting in the u	inderlying c	ause givi	en in Part I	l.			_	o the cause of c	
al Reco	: The law re cate has be ; page 2 shd	Completed									24a. Was auto perf 1 Yes			utopsy findings completion of c	
ivision	or Attending fter death. Jirector: Aftein by the fune	Certification; To Be	25. Was case referred to medical examiner? 7 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investic 3 Suicide 6 Could determ	Hospital: 1 28a. Date 04/12 gation not be 28e. Place	of Injury 8 / 05 ear e of Injury - A ling, etc. (Spe	t home, farm, st	of 2 MM	8c. Injury Work	er: 4□ Ni y at k?	ursing Ho	28d. Describe) RUGO 28f. Location City or To	how injur	y occurred V IMPL d Number or R	Cocity) AT SC	A CAIL
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier 1 Certifyin (Check only one)	og Physician: To the Exeminer: On the b and man	e best of my l	knowledge, deal	h occurred ivestigation	at the tin	ne, date ar pinio <i>n</i> , dea	nd place, ath occurr	and due to the	cause(s)	and manner a	s stated.	
	To the within To the comp	2	29b. Signature and title of certifie	melh	ell	M		O.C.	e number M.E			29d. Da	e signed (Moni	th. Day, Year) 2005	
			30. Name and address of person	B. KUY	2-c 11	tem 23a) (Type 1 PENN	STREE	T,BA	LTIM(ORE,	MARYLAN	ID 21	201		
	Sta Registi		31. Date filed (Month, Day, Year)	105 Alas	Registrar's Si	gnature									

			For State Registrar		State o	f Mar	yland / D		rtment o tificate			nd Mo	-	giene Reg. No.	00	n E	10001
	Physici /Medic		Decedent's Name (Fire Betty)		Joyce		Morto	on					2. Date of De Month April 24	Day	55	Year	7:46 A M
	Examin		4a. Facility Name (If not in MALCOLM GROW	_		mber)	***		4b. City, To					4c.		of Death	
	Funeral Director		5. Social Security Number 517–36–0984		M 2 13/15	7. Age (In yrs. last birtl Y	hday) (rs.	If Under 1 Months D	/ear lays	If Under 2- Hours	4 Hrs. Min.	8. Date of Birt (Month, Da August	h			lace (State or Foreign try) Oregon
	Aaryland I show	or		edent o. County ince Geor	voo!o	1	0c. City, Town									1	0d. Inside City Limits 1 ☐ Yes 27 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ir portent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinating in utilitied at 20.00.	Funeral Director	10e. Street and Number 4612 Westrid		ge s	1	Temple	111.	10f. Zip Co	ode 0748				_	izen of V USA	Vhat Coun	
036	ours after de rai', or items Examination	þ	11. Marital Status 1 Never Married 3 Widowed 4 1		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gir Year or D	orces? 2⊠No ve	er in U.S.		/as Deceden Yes, specify ☐ Yes 2%		panic Origi , Mexican, Specify:	in? (Spec Puerto F	cify Yes or No Rican, etc.)	-		e - Americ k, White, o : Whi	etc.
Maryland 21215-0036	within 72 ho ene. than "natui tis Mudiful	Completed	15. (Specify on Elementary/Secondary	Decedent's Edunly highest grad	cation e <i>completed)</i> College (1-4or 5+)	16a.	life. D	ent's Usual C kind of work of NOT use	retired)	ion ring most (of workin	g			unty S	chools
yland 2	should be filed ind Mental Hygi s marked other umatic event, I	To Be Co	17. Father's Name (First, George G. E							-			(First, Middle, E. Polla		Sumam	re)	
	and 2 sho ealth and m 27 is m		19a. Informant's Name/F George J. Mor	ton / Hus			46	512 V	Vestrid	e Pl		mule	Route Number	Mary1	and	2074	88
Baltimore,	permit. Pages 1 Department of H Ir portent: if ite ary injury or ott		20a. Method of Disposition 1 □ Burial 2 □ Cre 4 □ Donation 5 □	emation 3 F Other (Specify)		State	20b. Place of cemeter, Kalas (rema L'rema	atory or other	r place)	Apı	ril 2	6, 2005	Edgew	ater		land
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rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant	t conditions co	ntributing to d	eath but	not resulting in	the un	derlying cau	se giver	in Part I.						e cause of death?
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of Vit	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to examiner? 1 ☐ Yes 2XXVo		lospital: 1XX	Inpatient	2 ☐ ER/Out	tpatient	3□ DOA	Other			Check on o		6 □Oth	er (Specify	')
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	(1)	Sar	David A	. Norto	n MD	10	50 West	t Pe	erimet	er l	Road	Andr	ews AF	В, М	D 2	20762	one care care of
E	Sta Registi		31. Date filed (Month, Da APR 2	6 2005	See	iegistrar'	Signature	2000	2								

			For State Registrar	State of Marylan	d / Depa		Health an	d Mental I		9	
	Physici	an	1. Decedent's Name (First, Middle, Last) NELLIE M. McCONKEY					2. Date o	Death Da	y Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give s			4b. City, Town	, or Location of D	Apri Death		2005 County of Deat	8:55 p M
			7730 Hanover Parkw 5. Social Security Number 6. Sex	ay 7. Age (In yrs. i	ast birthday)	Green		Hrs. 8. Date o	P:	rince Ge	
	Funeral Director			M 2 🗓 56	Yrs.	Months Day	/s Hours I	Min. (Month Dec.	Birth Day, Year) 8, 19		thplace (State or Foreign puntry)
	Aaryland I show	ō	10a. State 10b. County		y, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-	Director	Maryland Prince Ge 10e. Street and Number	eorge's Gr	eenbel	10f. Zip Code	9		10g. Ci	tizen of What Co	ountry?
	th with	a D	7730 Hanover Park	way		207	70		П. 9	S.A.	
36	be filed within 72 hours after death with the Maryland tal Hygiene do ther then "netural", or items 23a or 28a-f show ovent, the Medical Exaft her must be indiffed at	by Funeral (11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Was Decedent Ever in U. Armed Forces? □ Yes 2 ☑ No If Yes, Give		Was Decedent of If Yes, specify C	of Hispanic Origin uban, Mexican, P No Specify:	? (Specify Yes o uerto Rican, etc.		14. Race - Ame Black, White	e, etc.
9	2 hour	ed t	15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual Oc	cupation		16b. K	(ind of Business/	White Undustry
212	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne durina most ai	f working			
Maryland 21215-0036	filed with Hygiene. other than	Соп	Elementary/Secondary (0-12)		Admin	istrati	ve Assis			rivate B	Business
and		Be	17. Father's Name (First, Middle, Last)					Name (First, Mid	.,	n Sumame)	
IT J	d 2 should be ith and Mental! I is marked of traumatic eve	ဥ	Mervin Lucas 19a. Informant's Name/Relationship (Typ.	pe. Print)	19b. Mailir	na Address (Stre	eet and Number o	availabl or Bural Boute No		or Town, State, 2	Zin Code)
	nd 2 lith a 27 is r trau		Ronald E. Nicholson				eet, Dea				.,
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	lace of Dispo emetery, crei	sition (Name of natory or other p	olace)	Date	20c. L	ocation - City or	
I iii		1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lucins	Geor	ge Wash	nington C	Cemetery 4	/26/200	Ade	lphi, M	aryland
Ba	permit. Departr Importu any Inji		21. Signature of Puliforal Service Contract	1/2			dress of Facility (timore A				
			23a. Part 1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death						Lite, MD	Approximate Interval Between
	Fnysician /Medical		Immediate Cause (Final disease of condition resulting in death)	Metastatic		all cel	1 lung c	ancer			Onset and Death 8 months
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8760,	icate be physicii s the bu	dicai	d	·	-						
9. Box 6	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3	Ectopic pregna Other (specify,		10 2011 215		23d. Date of del Month	ivery Day Year
P.0	that the ed by detacl		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
ords,	w requires been sign should be	ted by							Yes 2		obably 4 Unknown
I Records,	The larate has	Completed						_ a	Vas an utopsy erformed?	prior to death?	atopsy findings available completion of cause of 2 No
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:				Death (Check of			
of	ding Phys h. After this funeral dii	tion: To	1 ☐ Yes 2 ☒ No	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Ir	Other: 4 Nursi	28d. Descr	Residence ibe how inju		cify)
Division	in Plan	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office	СӨ	28f. Location City on	on (Street ar Town, State	nd Number or Ru e)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in m	e time, date and pay opinion, death	place, and due to occurred at the ti	the cause(s me, date and) and manner as d place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Da	te signed (Monti	h, Day, Year)
١) Little			D5	6024		Apr	il 25,	2005
R	(12)		30. Name and address of person who co Kenneth L. Abbott			Print)		Prince	1		New
	St. Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2005	2. Registrar's Signa	iture	2000	ce 110,	TITHCE !	reuel	ick, rid	r y ranu

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Louise Mayhew 2005 April 3:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 1 F Director 219 64 5146 51 Sept. 27, 1953 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Ast be notified at 1 ¥Yes 2 ☐ No Director Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 33 Briarcrest Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 🙀 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental is marked Kenneth I. Driscoll ည Anne L. Rogge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nit. Pages 1 and 2 s partment of Health ar portant: If Item 27 is Anne L. Driscoll / Mother 33 Briarcrest Drive Ocean Pines, Maryland 21811 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or * 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery 4/26/05 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ě in the past 12 months? 1 ☐ Yes 2 DNo Year Day 4 Pregnant at time of death 5 Other (specify) Deb P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Vital 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA In atient o 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending death. investigation 1 Tes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the h 29b. Signature and little of certifie 29d. Date signed (Month, Day, Year) 5 ause of death (Item 23a) (Type, Print) odella 31. Date filed (Month, Day, Year) APR 25 Registrar's Signature State 2005 Registrar

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			_ State	State of Maryland	l / Depa		lealth and	Mental Hy		2005		0.7
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of I	Death
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	/Medic		4a. Facility Name (If not institution, give si			4b. City, Town, o	r I ocation of Dea			County of Death		
	Examin	er	Bel Pre Nurs	Ce	enter		r Spri			Montgo		
			5. Social Security Number 6. Sex			If Under 1 Year	_		th	_	<u> </u>	r Foreian
	Funeral Director			^{M 2□ F} 65	Yrs.	Months Days	Hours Min		8 Year)	40 Vi	place (State or intry) rgini	а
		ŀ	Usuel Residence of Decedent									
	yland		10a. State 10b. County		Town or Lo						10d. Inside Cit	y Limits
	Mar First	ţ	MD. Charles	s Whi	ite P	lains					1∭ Yes	2 No
	r 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	ten of What Cou	intry?	
	hours after death with the Maryland turel', or Itama 23a or 28a-f show al Examiner must be notified at		10463 Markby	y Court			20695		Uni	ted St	ates	
	deal	Funerai	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	3. 13. V	Was Decedent of H	dispanic Origin? (Specify Yes or No	- 1	4. Race - Amer Black, White		
٩	or its		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	į .	Yes 20 No	Specify:	,				
200	raf.	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		74	opoury.			Specify. B1	ack	
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2	ygier lygier her ti		5	l		CO FICCII		one (First Middle			116	
ב	be fill Hital H od otl	Be	17. Father's Name (First, Middle, Last) Roy Tyler					me (First, Middle, McCowil		Sumame)		
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Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Wilbert Androw)			ng Address (Street						CO.
	l and lealth im 27 her t		Wilbert Andrew	PICCOWIII, DI	ace of Dieno	sition (Name of	by CL.,	Oate 22	PIA	ilns, M	la. ZU	695
Baltimore,	Pages 1 and ment of Heal ant: If item ury or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	emoval from State Ples	metery crem	natory or other place Grove	Bapt. Api	2005 23,	Co	lumbia	. Va	
Ē	tant:										, · · · ·	
3a	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service License	θ	22	Name and Addre	oss of Facility On Fune	eral Hor	ne			
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Ŧ			23a. Part1. Enter the disease, or complications, or heart failure. List only on	eations that caused the death. e cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Betw Onset and D	ween
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4	/Medical Examiner		resulting in death)	Due to (or as a consequ				1 5:				
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	g ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):							
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P.O. Box	atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□	Ectopic pregnanc	у		-	23d. Date of deli- Month		/ear
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	- S	_ Cities (specify) _						
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ds,	w requires that been signed t should be deta	d by			177	, ,		1 🗆	Yes 2[]No 3∏Pro	bably 4 ⊠U	Jnknown
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že	has has	шb						auto	DSV		ompletion of ca	
a				<u>.</u>					ormed? 2☐ No	1 ☐ Yes	2 🗆 No	
Vital Records,	iciar certif recto	Be	25. Was case referred to medical examiner?	ospital:		_ Ott	ner Tie	eath (Check only				
	Attending Physician: The la r death. cdeath. ector: Atter this certificate has by the funeral director, page 2	-T	1 ☐ Yes ※☐ No 27. Manner of Death	Inpatient 2 t	ER/Outpatier 28b. Time o	IL 3 DOA	Nursing	Home 5 ☐ Resi			rify)	
L C	ling After funer	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No	Esta. Doscribo	now injury	y cocurred		
Division of	death death stor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me larm str		,103 2	281 Location /	Street an	d Number or Ru	ra I Boute Num	her
<u>></u>	or A after Direction by	ertit	4 Homicide determined	building, etc. (Specify		oot, lactory, cilioo		City or To				
_	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Ü	29a. Certifier 1 ✓ Certifying Phys	ician: To the best of my know	wledge deat	h occurred at the tr	me, date and place	ce, and due to the	cause(s)	and manner as	stated	=55.00
	24 h	edicai	(Check only 2 Medical Examinate)	ner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29c. Licens	se number		29d. Dat	e signed (Month	, Day, Year)	
)	- s + ō) /-	7 N. M.	1	D	50545		Аp	ril 21	, 2005	5
\	(i)		30. Name and address of person and co	mpleted cause of death (Item	23a) (Tyne	Print)						
	U		Godswill O.				Hampshi	re Ave.	, Т	akoma	20912 Park	Md
	Sta	ate	31. Date liled (Month, Day, Year)	Registrar's Signat	hire				,			
	Regist		APR 2 5 2005	Blow &	600	w						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Doris X. Murdock April 17 2005 1:38 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6701 Alpine St., #5 Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1□M 2\ F 579-58-4251 Director 61 Wash., Usual Residence of Decedent with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23e or 28a-f shov the Medical Example Triust be notified at 1 Yes 2 No Director Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6701 Alpine St., #5 20747 United States filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Be Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth Homemaker Private Pages 1 and 2 should be filed w tment of Health and Mental Hygien tent: If item 27 Is marked other ti jury or other treumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wade Wyatt Margaret Basil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Murdock, Jr. - Son 509 Sentry Lane, Ft. Washington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 4/27/2005 Landover, MD 21. Signature of Fur eral Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cuse (Final disease or condition resulting in death) Pnysician Cardiopulmonary failure /Medical Due to (or as a consequence of): Examiner Uncontrolled diabetes Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physiclan/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Hypertension Years Due to (or as a consequence of): Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed 1 🗌 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 XYes 2 □ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical callying registration to the best of my knowledge, death occurred at the limb, date and place, and due to the cause(s) and matrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) 33459 DC April 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dora Stadler, M.D. 110 Irving St., N.W. Wash., DC 20010 31. Date filed (Month, Day, Year 2. Registrar's Signature State APR 2 5 2005 Registrar

			For Stata Registrar		State o	of Maryla		artmen rtificate				lental Hyg	iene	05	15609
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	Examin	er	4a. Facility Name (If not			mber)				Location o	of Death			ity of Death	
	Eupovol		3716 Jeffe 5. Social Security Numb			7. Age (In yrs	. last birthday)	Hyat If Under		111e	24 Hrs.	8. Date of Birth (Month, Day,			orge's place (State or Foreign
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	pu >		Usual Residence of Dec	edent c. County		100.0	ity, Town or Lo	oation							10d Jasida Ciballimita
	faryla sho	ō		•	1										10d. Inside City Limits 11 Yes 2 No
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	oms 2	Funeral	11. Marital Status			edent Ever in l	J.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ace - Ameri	
36	or ite		1 Never Married		1 ☐ Yes If Yes, G	2∭ No ve		1 ☐ Yes		Specify:		riodii, oto.,	Spec		etc.
ö	72 hours after death with the Maryland Insturel', or items 23a or 28a-1 show disel Even liver must be notified at	q pa	3 🛣 Widowed 4 🗆	Decedent's Ed	Year or E	ates:	16a Dece	dent's Usua	I Occup	ation			16b. Kind of	Whi	
15	n "na	Completed by	(Specify of Elementary/Secondary	nly highest gra	de completed)		(Give	kind of wor DO NOT us	rk done d	turing most	t of worki	ing	TOD. KING OF	00311033/11	lousity
212	e filed within at Hygiene. I other than "	Com	12	y (0-12)	College (1-401 5+)	Fact	ory W	orke	r			Food	Proce	ssing
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yla	2 should be and Mental Is marked o	2	David Mil				_					cances F			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Manylan if Health and Mental Hyglene. item 27 Is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Ever it or traut he notified at		19a. Informant's Name/					-				Apt.#222			•
	1 and Health tem 27 other tr		Nellie She		Sister	20b.	Place of Dispo cemetery, crei				_		20c. Location		
υOπ	ages ant of at: If i		1 🕅 Burial 2 □ Cr 4 □ Donation 5 □			State					1/25	/2005 B	rantwo	od M	arvland
altimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funera			iro						ch's Fur			
Ö	Department Department		1 al mail	Month	mo,	70133						nue, Hya			
	Physician /Medical Examiner	iner	23a. Párt1. Enter the di shock, or heart fai Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlyin Cause, Obsease or injur	lure. List only	a	(or as a conse	quence of):	er me mon	10061	g, such as	cardiac c	or respiratory arre	951,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	fedical Examine	resulting in death) Last	<u> </u>	c	(or as a conse	quence of):								
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/ita	ysiclan: Th is certificate director, pag	Be	25. Was case referred t examiner?	o medical	Hospital:				0.1			(Check only on			
of	Q 50	- To	1 ☐ Yes 2 No 27. Manner of Death		28a. Date	Inpatient 2	ER/Outpatier 28b. Time o		A laws	4 □ Nu		me Stander			y)
on	ding After fune	tion		Pending investigation	(Mor	nth, Day Year)	Injury	M	8c. Injury Work	(? ∕es 2∐I	- 1	200. Describe no	w injury occi	urred	
Division	al or Attending safter death. I Director: After d in by the fune	Certification:		Could not b	e 28e. Place	e of Injury - At I ing, etc. (Spec		reet, factory			-	28f. Location (St. City or Town		nber or Rura	al Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edicai C	29a. Certifier 12 (Check only one) 2	Certifying Ph Medical Exar	niner: On the b	e best of my kr pasis of examin	nowledge, deat nation and/or in	h occurred a	at the tim	e, date an pinion, dea	d place, a	and due to the ca ed at the time, da	ause(s) and r	manner as s	tated. o the cause(s)
	To the H within 24 To the Fu	M	29b. Signature and title	of certifier	11/	(0)				number			d. Date sign	ed (Modern	Day, Year)
)			•	May	UK	EXC.	J	1	大	SUZ	_	-	4/	18/9	
	(10)		30. Name and address of	+ 1-K	completed cal	of death (Ite	em 23a) (Type, 20 /	Print)	and	R	/ (Med	ne)	
	Sta Registi		31. Date filed (Month, D	ay, Year)	See.	Registrar's Sign	Spa	2							

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of M	laryland / D	epartment of h	Health and M	•	_	ile.
			Registrar		(Certificate of	Death		eg. No. 4 U	15 15510
Phy	ysicia	n	Decedent's Name (First, Middle	, Last)				2. Date of Deat Month	Day	3. Time of Death
//\	ledica	al		Anthony Ma		4. O. T.	or Location of Death	April	23, 2005	
Ex	amine	er	4a. Facility Name (If not institution Shady Grove I	_			cville		4c. County o	
Fun	oral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birth	day) If Under 1 Year		8. Date of Birth		1tgomery 9. Birthplace (State or Foreign
Dire			213-90-5296 Usual Residence of Decedent	1ÅM 2□ F		rs. Months Days	Hours Min.	Dec. 31	, 1961 W	9. Birthplace (State or Foreign Country) Vashington, D.C
17215-UU36 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show	=		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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I 5-UU36 172 hours after death with the Marylan "naturel", or Items 23a or 28a-f show	0 9	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	hat Country?
ath w	Tan I	ra	25400 Aiken Dr			208				U.S.A.
er de Items	1	Funeral	11. Marital Status	12. Was Deceden	?	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
rs aft	T BI		1 XNever Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	1	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
Z1Z15-UU36 d within 72 hours af giene. ar than "natural", or	9	ed	15. Deceden	t's Education		Decedent's Usual Occup	pation		16b. Kind of Bus	
5 Find 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	W	pie	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or		Decedent's Usual Occup Give kind of work done life. DO NOT use retire		ing		ŕ
V DOL	2	Completed by		3	1	Exhibit Ass	embler		Constr	uction
be file	vant	Be (17. Father's Name (First, Middle,	_			18. Mother's Name		Maiden Sumame)
		2	Richard D.	Malone					Glaser	
Maryland d 2 should be file th and Mental Hy 7 is markad oth	mne.		19a. Informant's Name/Relations	hip (Type, Print)	19b. i	Mailing Address (Street	and Number or Rura	al Route Number	City or Town, S	State, Zip Code) 21532
a an an an	thart		Peter A. Malone 20a. Method of Disposition	e - Brother	20h Place of I	501 Hoffman	Hollow B	oad, Fi	rostburg	Mary Land City or Town, State
MOF Pages hent of H	or of		1 ☐ Burial 2 X Cremation			Disposition (Name of crematory or other pla				
Baltimore, permit. Pages 1 ar Department of Hea Important: If Itam 3	njury	-	*4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Metrop					ia, Virginia
Der made	any			1/01		Olin L. Mo	lesworth	P.A., Fu	uneral H	lome
1-14-1			23a. Part1. Enler the disease, or shock, or heart failure. List	complications that cause	ed the death. Do no	26401 Rids	ge Road,	Damas cus	s, Maryl	and 20872-011 Approximate
618			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	(-1) (- / - / - / - / - / - / - / - / - / -	2	a respiratory arre	501,	Interval Between Onset and Death
Physic /Med	_		disease or condition resulting in death)	a. Gast	s a consequence of	tinal he	morris	rge		hours
Exami						cirrhosis				manth.
4	4	ē	Sequentially list conditions, if any, is aury to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	s a consequence of					
cuted	ansit	Examiner	Cause (Disease or injury that initiated events	alc	pholis	n				years
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c 58 artifica ing ph	a as t	Med	IF FEMALE:		_	-				
Hecords, P.O. Box 68 The law requires that the death certifica te has been signed by the attending ph	or us	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	у		23d. Date Mont	
at the deg	hed fo	Sici	1 Yes 2 No	4☐Pregnant a 9☐Unknown	at time of death	5 Other (specify)			INIOITE	ii Day real
that th	detac	Ph)	Part II. Other significant condition	one contribution to death	but not resulting in	the underlying cause on	von in Part I	23e Did tob	acco use contrib	oute to the cause of death?
dires t	pe	l by	1 21(11)	mo commodurg to accum	but not rosalling an	ario ariabily and badde gri	VOITIETT CITY.	1 ☐ Ye	1	B ☐ Probably 4 ☐ Unknown
ecords, law requires tas been signer	lnous	etec				·		-		
HeC he lav e has	19 2	Completed						24a. Was ar autops perform	y pri	ere autopsy findings available ior to completion of cause of eath?
	r, page		06 11/					1 ☐ Yes	22(No 1	Yes 25 No
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al or safte	i p	Certification;	4 Hornicide	building, e	etc. (Specify)		1	City or Town	, State)	
DIVI To tha Hospital or At within 24 hours after or To the Funaral Dirac			29a. Certifier Cartifyir	ng Physicien: To the bes Examiner: On the basis	t of my knowledge,	death occurred at the til	me, date and place,	and due to the ca	use(s) and man	ner as stated.
ha H in 24 he Fi	plete	edicai	one)	and manner s	stated.					
To tha within 2	Com	Σ	29b. Signature and title of certifie		5 MA	29c. Licens	se number	25	9d. Date signed ((Month, Day, Year)
			/	J. Mist	7 1011-	05	7 /30	1	tpril.	25, 2005
6			30. Name and address of person	who completed cause of	death (Item 23a) (T	ype, Print)	00.10	Drive	Pack	(Month, Day, Year) 23, 2005 wille, Mp 2083
_				1011317	t / U /	MICUICA	Juper	2717		, , , , , , , , , , , , , , , , , , , ,
THE DA	Stat	е	31. Date filed (Month, Day, Year)	6 2005	trar's Signature	Board ;				

BRENCH MC DW FFILE Limore, Maryland 21215-0036

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		State of Maryland / Department of Health and M	•	
		For State of Walfyland / Department of Health and W		2005 150
		Decedent's Name (First, Middle, Last)	2. Date of Death	
Physic		Brenda Leetta McDuffie	Month APRTI.	Day Year 25.2005 3:45 A M
/Medi Examii		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
		CIVISTA MEDICAL CENTER LAPLATA		CHARLES
Funeral		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 22	9. Birthplace (State or Foreign Country)
Director		577 - 54 - 0378	Sept. 22	, 1940 Washington, DC
yland sow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Man Fied	ţ	MD Charles Benedict		1 ☐ Yes 2 X No
ith the or 28	Funeral Director	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?
ath w 23e	la I	18814 Patuxent Ave., P.O. Box 89 20612		USA
er de Iteme	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spin Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 1 ☐ Yes 2 M No Specify: Year or Dates:		Specify: White
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6. "n) ple	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) (Give kind of work done during most of work life. DO NOT use retired)		
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be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name No. 11. Father's Name No. 11.	e (First, Middle, M Ruth Woo	
Id yid it Z 12.13-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23e or 28e-1 show aumatic event. It we Medical Examinar must be instilled at	ြိ	they are the same and the same are the same		
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Heal Heal				Orge, VA 22485 20c. Location - City or Town, State
Pages ent of nt: If i		1 \(\mathbb{B}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) \[\begin{array}{ccessed constant of the place of the pla	8-2005	Waldorf, MD
Datiliore, IVI permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Sign Tyre of Funeral Service I ce see 4000F2 22. Name and Address of Facility		na raor i y rib
Dermi Depar Impor any ir	V) 11	Huntt Funeral Hol P.O. Box 156, Wa	me ldorf, M	D 20604
		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		st, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition CARCINOMA 0F	ung	Onset and Death
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VICAL INECCIOUS, F.O. BOX 00/00, sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	cal	d		
rdiffical ing phy	Physiclan/Med	IF FEMALE:		
ath cer titlendir	lan/	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
the a	sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		Day 1ea
that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
law requires as been signi	d by	INTRAABDOMINAL BIEEDING	1 □ Ye	s 2 No 3 MProbably 4 Unknown
w red	Completed	THROM BUCYTOPENIA	24a. Was an	24b. Were autopsy findings available
The la	шо		autopsy perform	prior to completion of cause of death?
vician: 1 ician: 1 certifical ector, p	BeC	25. Was case referred to medical 26. Place of Death	1 Yes 2 h (Check only one	/•
Physic this ce ral direc	To	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 Other (Specify)
tending Physician: The I feath. Isaah. tor: After this certificate he the funeral director, page	on:	1 Month, Day Year) Injury Work?	28d. Describe ho	w injury occurred
or Attending after death. Director; After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	206 Location /Cts	The state of March 2011 Section 1
Olf A after A Direction by	Certification;	4 Homicide determined determined determined determined	City or Town,	reet and Number or Rural Route Number, , State)
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Cherk only 20 Madical Expriser: On the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and manner as stated.
n 24 h	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	tte and place, and due to the cause(s)
To the comp	ž	29b. Signature and little of pertitier 29c. License number	29 A	od. Date signed (Month, Day, Year)
		D-44436	- /	Iphil 25 2005
(010		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	TTE 100	HAI DODE MD 20002
0100	ate	ASHVINKUMAR J. PATEL MD 102 PAUL MELLON CT. S 31. Date filed (Month, Day, Year) 32. Registrar's Signature) I E 1 U Z	WALDUKF, MD 20002
Regist		APR 2 6 2005 Eleme & Joseph		

			1 - For State Registrar	5	State of	Marylar		artmen rtificate			and M	ental Hyg	jiene eg. No.	nne)	15612
	Physici		1. Decedent's Name (First, Middl	e, Last)							i	2. Date of Dea Month	th Day	Yea		3. Time of Death
	/Medic		Sam Di		Nha	n						April	21,	2005		4:00 ам
	Examin	er	4a. Facility Name (If not institution			ber)				Location of	of Death		4c.	County of De	eath	
			13021 Atlant	ic A		Ann da	land birds do .)		ckvi	lle If Under	24 Hrs			Montgo		
	Funeral Director		5. Social Security Number 579-04-5066 Usual Residence of Decedent		2 ⊠ F ′	82	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Aug • I	Year)	922	Country Ch i	ce (State or Foreign r) na
	land ow		10a. State 10b. County			10c. Ci	ty, Town or Lo	cation							10d	. Inside City Limits
	Mary I sh	tor	Maryland Mont	gome	сy		Rock	ville								1 ☐ Yes 2 🔼 No
	h the	irec	10e. Street and Number					10f. Zip	Code			1	0g. Citi	zen of What	Country	n
	1h wi	ai C	13021 Atlanti	c Ave	enue			2	0851					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any jury or other traumatic event, lite Medical Examinational Legisla and once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mari 3 ☑ Widowed 4 ☐ Divorced	_	Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	X No	1	Was Deced If Yes, spec 1 ☐ Yes	ify Cuba	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ai Black, W Specify: W		2.
21215-0036	2 hou	ted	15. Deceden	t's Educat	ion		16a. Deced	dent's Usua	I Occupa	ation			16b. Ki	nd of Busines	ss/indus	stry
21,	thin 7 e. an "n	nple	(Specify only highe Elementary/Secondary (0-12)	st grade c	College (1-4	tor 5+)	life.	kind of wor DO NOT us	e retired	uring mosi)	t or workir	ng				
	ed wi	Con	12				Но	memak	er					Own Ho	me	
Maryland	be fill tal H d oth	Be	17. Father's Name (First, Middle,	Last)								(First, Middle,	Maiden	Sumame)		
<u> </u>	nould I Men narke	To	Troi Nhan		0.1.4						ih Da					
Mai	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relations Huy Thanh Ha/		Print)							Route Number				
e,	1 and Healt em 2		20a. Method of Disposition			20b. F	Place of Dispo	The American State of the Control of				Rockvi		cation - City		
Baltimore,	ages intot intot		1 Burial 2 □ Cremation		oval from SI	ale _	cemetery, crem ce of Hea				Apri:	1 28,				
를	artme ortani injury		4 □ Donation 5 □ Other (S21. Signature of Funeral Service			Gai					200					Maryland
Ba	Dep Imp onc		da . c	0	· P	-	F:	ranci 00 Un	s J. iver	Coll sity	íins Blvd	Funeral	Hot	ne Inc	· na	MD 20901
	Physician /Medical Examiner	er	23a. Part. Inter the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	only one	Parkir Due to (o	ch line.	Diseas quence of):		e of dying	g, such as	cardiac o	r respiratory arr	est,		In O	pproximate terval Between inset and Death O Years
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (o	r as a consec	quence of):									
P.O. Box	that the death certific ted by the attending p detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c.	1 Live bin	ome of pregna th 2 Peta nt at time of d vn	ıl déath 3 □	Ectopic pro Other (spe					2	3d. Date of d Month	lelivery Da	ay Year
Ś	D 0	d by Pr	Part II. Other significant condition Diabetes Melli	tus,	outing to dea Hyper	th but not res	sulting in the u	nderlying ca	ause grve	en in Part I.						cause of death?
Vital Record	9 4 9	Completed by										24a. Was a autops perforr	y ned?	prior to death	o compi	findings available letion of cause of
ta	ilcien: Th certificate rector, pag	0	25. Was case referred to medical							26 Place	of Death	1 Yes 2		1 🗆 Ye	es 2[□ No
	Physicien: Tribis certifica	To B	examiner? 1 ☐ Yes 2 X ☐ No	Hos	pital: 1 🗆 Inj	patient 2	ER/Outpatien	t 3 DO	A Othe	-		ne XX Reside		Other (Sc	oecify)	1.17.
ion of	Attending Ph r death. ector: Atter th by the funeral		27. Manner of Death 1 X Natural 5 Pendir 2 Accident Investi		28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M 2	Bc. Injury Work		2	8d. Describe ho				
Division	s after death	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place o building	f Injury - At h g, etc. <i>(Specit</i>	ome, farm, str	eet, factory	, office		2	8f. Location (St City or Town			Rural R	oute Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edical	29a. Certifier 1X Certifyir (Check only one)	g Physic Exeminer	an: To the b : On the bas and manne	is of examina	owledge, death	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the ca	use(s) ate and	and manner place, and di	as state	ed. e cause(s)
	To the vithir comp	Z	29b. Signature and title of certifie	r				29c		number				signed (Mo		
}) In						D 5	4486	,	/	98RI	L 24	, 20	005
	V		30. Name and address of person Huyanh Ton, M	.D.	7505	New Ha	mpshire	e Ave	., #	310,	Tako	ma Park	, мі	2091	2	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5	2005	32 Re	gistrar's Signa	ture to	who		•						

			1 - For State Registrar		State	of Maryla	and / Dep <i>Ce</i>		nt of F			lental H		13 1	inc	
	Physic /Medi		Decedent's Name (Firs Man		Lill	ie	Prin					2. Date of Month		Day	Year	3. Time of Death
	Exami		4a. Facility Name (If not in	_				_	y, Town, o	r Location	of Death	April	19,	200 4c. Coun	by of Death	12:25 A "
			1417 Sout		w Dr.	#101		_	on Hil	_					e Geom	œ's
	Funeral Director		5. Social Security Number 579–64–4575		Sex 1 ☐ M 2 🖾 F	7. Age (In y	rs. last birthday, Yrs.	Month.	er 1 Year S Days	If Unde Hours	Min.	8. Date of I (Month, August	Day, Ye	ar)	9. Birtho	place (State or Foreign try) ngton, D.C.
	and		Usual Residence of Dece 10a. State 10b.	County		10c	City, Town or L	ocation								
	e Marylan 8a-f ehow	Director	MD Pr	ince Ge	oge's		Oxon Hil								1	0d. Inside City Limits 1 Yes 2 No
	with the or 20	Dire	10e. Street and Number	- "	404				ip Code				10g.	Citizen of	What Cour	ntry?
	eath	eral	1417 Southvie	w Dr. #					20745					U.	S.	
920	72 hours after death with the Maryland neture!', or Neme 23s or 28s-1 show after Examiner coust be redified at	by Funeral	11. Marital Status 1 Never Married 2 3 X Widowed 4 D	_	Armed F	2 No		Was Dec If Yes, sp	ecity Cuba	spanic Or n, Mexica Specify	n, Puerto	ecify Yes or f Rican, etc.)	No-		ce - Americ ack, White, fy: E	
5-0	72 hours "neturel", dical Eus	etec	15. D (Specify only	ecedent's Ed	ducation ade completed)	16a. Dece	dent's Us	ual Occupa	tion	nt of unde		16b	. Kind of E	Business/Inc	dustry
2121	be filed within 72 h ital Hygiene. id other than "netu event, the Madical	Completed	Elementary/Secondary			(1-4or 5+)	lite.	öö‰it ∞d Har	use retired)	si oi worki	ng		bod Se		,
Maryland 21215-0036		To Be	17. Father's Name (First,) William A. Mo									ia McAr		len Sumai	ne)	
	d 2 sho th and 7 is m traum		19a. Informant's Name/Re Francine Haski			ughter	19b. Mailie 1417	ng Addres	s (Street a	nd Numb	er or Rura	Route Num	ber, Cit	y or Town	, State, Zip	Code)
Baltimore,	of H		20a. Method of Disposition 1 2 Gurial 2 Crem 1 4 Donation 5 0	nation 3 🗌	Removal from	State	Place of Dispo cemetery, crer	matory or	other place	9)	4-26-4	os 05	1		City or To	•
Balt	permit. Pege Department Importent: If eny injury or once.		21. Signature of Funeral S	ervice Licen	500	Call	2 K 22	2. Name a	nd Addres	s of Facili	bane F w	ette & A C 20018	SSC			
	3		23a. Part1. Enter the dise shock, of heart failure	ase, or comp	olications that	caused the de	ath. Do not ent	er the mo	de of dying	, such as	cardiac o	r respiratory	arrest.			Approximate
Y	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a B	least Co	ma									Interval Between Onset and Death
12	Examiner		Sequentially list conditions		b											
Т	nsit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	°	Due to	(or as a conse	equence of):									
ó	execuent and rial-tra	Еха	that initiated events resulting in death) Last		C. Due to	(or as a conse	equence of):									
68760,	ficate be executed physicien and is the burial-transit	edical		·	d											
	The law requires that the death certific te has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 □ Yes 2 □ No			come of pregi	tal death 3	Ectopic p						23d, Dat	te of deliver	y Day Year
P. 0.	at the by the staches	hys	9 Unknown		9□ Unkno	own										,
Vital Records, I	w requires that been signed should be del	by	Part II. Other significant co	onditions co	ontributing to de	eath but not re	sulting in the un	iderlying o	ause giver	in Part I.				_		cause of death?
ဝင	ne law requ has been ge 2 shoul	Completed										24a. Was		24b. V	Vere autops	sy findings available
												auto perfo	ormed?		death?	letion of cause of
	Physician: r this certifica ral director, j	Be	25. Was case referred to m examiner?	-	Hospital:						of Death	(Check only	one)			
o	Phys or this oral dir	2: To	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 🗆 I		ER/Outpatient 28b. Time of			4 LJ NUI		e 5⊠Resi				
o	Attending Price death.	atloi		ending vestigation		h, Day Year)	Injury	M	8c. Injury a Work?	n s 2 □ N		3d. Describe	now inji	ury occurr	ed	
	in Pite	Certification:	3 Suicide 6 0	Could not be letermined	28e. Place buildir	of Injury - At h	nome, farm, stre	et, factory				Bf. Location (City or To	Street a wn, Stal	nd Numbe	er or Rural I	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (29a Certifier 1 X Ce (Check only one) 2 ☐ Me	rtifying Phy dical Exami	sician: To the iner: On the ba and mann	best of my kn isis of examinater stated.	owledge, death ation and/or inve	occurred estigation,	at the time in my opir	, date and	place, an	id due to the d at the time,	cause(:	s) and mai	nner as stat	ed. ne cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of c						. License r						(Month, Da	
0	(2)		10 C	LA	-co)			245880					21–05		
1	3)		30. Name and address of per Leon Hwang, MD	1221 M	ercantile	e of death (Ite	m 23a) (Type, P	rint) 2074	1							
	Stat Registra		31. Date filed (Month, Day, APR 2	Year)	■ Be	anistrar's Sign										

	Physici		CK 1 - State Amend Item 1. Decedent's Name (First, Middle, La Dwayne	4a per me s:) e Edward F		Gettificate of	Death tas	2. Date of De Month	aatn	3. Time of Death 0957 A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deal		4c. County of	
90		М		REET		ABERDEE			HARFO	
5	Funeral Director		5. Social Security Number 6. S 217–82–7673		e (In yrs. last birt 29	Yrs. Months Days	Hours Min.	(Month, Da	ay, Year) LO,1975	9. Birthplace (State or Foreign Country) Maryland
V			Usual Residence of Decedent		10- Cit. T					
	Aaryla f show	ō	10a. State 10b. County Maryland Harf	ord	10c. City, Town		rdeen			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28e-	irect	10e. Street and Number			10f. Zip Code	- deen		10g. Citizen of Wh	at Country?
	ath with	rai D	7 East Aztec Str	eet			21001		Ü	J.S.A.
	ler dez	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Race - Btack,	American Indian, White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28e-f show ont, the Medical Examiner must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	110	1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wo	rking	16b. Kind of Busi	
121	within ene. than	dwc	Elementary/Secondary (0-12) Eleven Years	College (1-4or 5	5+)	Mason	d)			n Masonry n, Maryland
	be filed withintal Hygiene. ed other therevent, the Mevent, the Mevent, the Mevent.	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Surname)	
Maryland	2 should be f and Mental H Is marked of reumatic ever	To I		W. Patricl			<u> </u>		e Cornett	
Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Delmar W. Patrick	• • • •	ther) P	Mailing Address (Street	and Contown	ural Route Numb 11g0 e posit	er, City or Town, St Maryland	^{ate,} 21918 - 21904
ē,	s 1 and 2 of Health item 27 I		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other place	1	Date	20c. Location - Ci	
Baltimore,	Page ment c ent: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specify			ottingham Ceme		04/05	Colora,	Maryland
Balt	permit. Pages 'Department of H fmportent: If ite any injury or of		21. Signature of Funeral Service Licer	CTTE NO	1.51.	22. Name and Addre Lee A. Pat	terson &			e, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do n	oot enter the mode of dying	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Methadon						Onset and Death
	Examiner			Due to (or as	a consequence o	01):				
	P H	iner	Sequentially list conditions, Tay loading to an accuse. Enter Underlying Cause (Disease or injury	Due to (or as	а остановний с	rj:				
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	of):				-
760,	e be e /sician e buriz	ai		d						
89	leath certificate t attending physis I for use as the t	Medi	IF FEMALE:							
Вох	ath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy	4		23d. Date of Month	
P.O.	that the de ed by the a detached to	Physician/Medic	1 Yes 2 No 9 Unknown	4□Pregnant at 9□ Unknown	time or death	5 Other (specify)				
	Hospitel or Attending Physician: The law requires that the death certificate 24 hours after death. Punerel Director; After this certificate has been signed by the attending phystely filled in by the funeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause give	ren in Part I.			ute to the cause of death?
COL	aw requires as been sign 2 should be	Completed						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
- Re	The la	Som							psy prio prmed? dea 2 □ No	or to completion of cause of the? Yes 2 □ No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospitat:		Oth		ath eck onl		
o to	tending Physician: leath. tor; After this certific the funeral director,	o: To	1 X Yes 2 No 27. Manner of Death	28a. Date of Inju	rv 28b T	ime of the 28c. Injur	4 Nursing F		dence 6X10ther how injury occurred	(Specify) AT SCENE unk
ion	utending death.	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	4-11/1	y Year) In	njury Wor	k? Yes 2. X No			u
Division of Vital Records,	l or Atten after deat Director:	Certification:	3 ☐ Suicide 6 🛣 Could not be determined	28e. Place of tnj building, et Home	ury - At home, far c. (Specify)	rm, street, factory, office		28f. Location (: City or Too Aberdee	wn, State) 7 E.	or Rural Route Number, Aztek St.
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	ledical C	29a. Certifier 1 Certifying Ph	ysician: To the best	f examination and	, death occurred at the tir Vor investigation, in my o	ne, date and place	and due to the	cause(s) and mann	er as stated. If due to the cause(s)
_	To the within 2 To the comple	Med	29b. Signature and title of certifier	and marmer sta	ateu.	29c. Licens			29d. Date signed (i	
			* Clorker	M		0.0	.M.E		MAY 1, 2	2005
			30. Name, and address of person who	completed cause of d		Type, Print) PENN STREET	, BALTIMO	ORE.MARY	LAND 2120)1
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature					
			MAY - 4 2005	Malue	is he	ALL CALL				

			For	State of Mar	yland / Dep	artment of l	Health and	d Mental Hy		nor	\$ strong
			1 - State Registrer		Ce	rtificate of	Death		Reg. No. 💪	000	15615
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examin	al	Paul Mark Pellicon 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D	April eath	4c. Cou	2005 Inty of Death	8:00 P M
		•	Union Hospital of			E1kton	T 1/2		Ceci		
	Funeral		5. Social Security Number 6. Se	x 7. Age (i ŽM 2□F	In yrs. last birthday Yrs.	Months Days		Ain. (Month, Da		9. Birthpl Count	lace (State or Foreign try)
	Director		Usual Residence of Decedent		75 ''			Jan.19	,1930	Penns	ylvania
	ow ow		10a. State 10b. County	1	0c. City, Town or L	ocation				10	0d. Inside City Limits
	Man,	to	Maryland Cecil	C	onowingo						1 □Yes 2 No
	r 28s	Director	10e. Street and Number		OHOWINGO	10f. Zip Code			10g. Citizen	of What Coun	try?
	23a o		431 East Red Hill	Road		21918			United	State	S
	dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.		Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. F	Race - America Black, White, e	an Indian,
9	or th	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 X No		00110 7110211, 010.,		ncify: Whi	
Ö	ural",	d by	3 ☐ Widowed 4XXX ivorced	Year or Dates:						·	
75	within 72 hours atter death with the Maryland ene. than "natural", or items 23s or 28s-f ahow the Modical Eschirbar must be multified at	lete	15. Decedent's Edi (Specify only highest grad	de completed)	(Giv	edent's Usual Occu e <i>kind of work d</i> one DO NOT use retire	during most of			f Business/Ind	,
12	within she. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		av Worker	•			ore Co	•
2	Hygin other ent,	Be C	17. Father's Name (First, Middle, Last)		птВим	ay worker		Name (First, Middle			tenance
au	ould be Mental arked o	To B	Frank Pellicone				Elsie	Strunk			
Maryland 21215-0036	2 should be filed within 72 hours atter death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23s or 28s-f ahow aumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Stree	t and Number o	r Rural Route Numb	er, City or To	wn, State, Zip	Code)
	and 2		Mary Friesland/Sis	ster	431 E	ast Red H	lill Roa	d,Conowin	go,Mar	yland :	21918
ore	of He of He roth		20a. Method of Disposition Burial 2 Cremation 3 🔲	Removal from State		matory or other pla		Date	20c. Locatio	on - City or To	wn, Slate
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es		`4 □Donation 5 □ Other (Specify		North Ea	st Method etery	list Ap	ril 27,	North	East.Ma	aryland
3a It	permit. Depart Import any inj once.		21. Signature of Funeral Service Doens	600	2	2. Name and Addr		Crouch Fu	neral	Home	
<u> </u>	20 E # 9		Colol & Ci	ril				reet,Nort		,Maryla	and 21901
Е			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	e death. Do not er	iter the mode of dy	ing, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. actl	mycous	Inta	ella				Onsot und Dough
	Examiner		ſ	Due to (or as a c	consequence of):	0					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):	lle_					
}	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Divit	es neal	4					
o_	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a c	consequence of):						
3760,	he he	lical		d							
<u>څ</u>	leath certifica attending ph I for use as tl	Physician/Med	IF FEMALE:								
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnanc	Э			Date of deliver Month	ry Day Year
o.	the de	ysic	1 Yes 2 No	4□Pregnant at tin 9□Unknown	ne of death 5	Other (specify) _					,
_	res that the de signed by the a be detached f		Part II. Other significent conditions co	ntributing to death but r	not resulting in the	underlying cause g	ven in Part I.	23e. Did t	obacco use c	ontribute to the	e cause of death?
Records,	Juires n sign	d by						1 🗆	Yes 2 XN	3 ☐ Proba	ably 4 Unknown
00	w requir been si should	Completed						24a. Was	an 24	b Were auton	sy findings available
Re	he lav	mo						autoj	osy rmed?	prior to con death?	npletion of cause of
ta	ician: Th certificate rector, pag	60	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of	200 No	1 ☐ Yes	2 No
Division of Vital	Attending Physician: The sr death. ector: After this certificate his by the funeral director, page	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient	2 KER/Outpatie	nt 3□ DOA Ot	her	ng Home 5 ☐ Resi		Other (Specify)
0 U	ng Ph fter th neral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time			28d. Describe			
Sio	endin eath. or: Aft	catic	2 Accident investigation				Yes 2□No				
Ž	or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s (Specify)	treet, factory, office		28f. Location (City or To		mber or Rural	Route Number,
	To the Hospital or Attentwith 24 hours after deall To the Funeral Director: completely lilled in by the	O	29a. Certifier Certifying Phy	minion T- the inch							
	To the Hospital within 24 hours a To the Funeral Completely lilled	edical	(Check only one)	vsicien: To the best of r iner: On the basis of ex and manner state	camination and/or ii	th occurred at the to restigation, in my	ime, date and pl opinion, death c	lace, and due to the occurred at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	and marmor state	u.	29c. Licen	se number		29d. Date sig	ned (Month, E	Day, Year)
	->-0		I m'cee &	a MD			823		4/2	alac	•
	/		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type	. Print)		1	12	05	
	り		JUI-CHIH	HSUM.Z). 22	3 W. 1	Town S	T. E/+/3	255 W	1 20	72/
	Sta Registi		31. Date filed (Month, Day, Year) APR 2. 6. 201	32 Registrar's	s Signature	anti)		t. E1+10	/		
			#30 a3 / f3 / []								

			Please Type or Print in Black Indelible Ink. Ensure	•		
			State of Maryland / Department of Health and Certificate of Death	_	glene 005 I	5616
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eath 3. Ti	ime of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath 4	2 2005 3 4c. County of Death	204P M
			University of Maryland Medical Ctv. Baltimore 5 Social Security Number 6 Sex 7, Age (In vrs. last birthday) If Under 1 Year If Under 24 F			
	Funeral Director			Ain. 8. Date of Bir (Month, Da Sept. 9	of the pay of the pay	-
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Ins	ide City Limits
3	e Maryland Sa-f show	Director	Maryland Wicomico Sharptown		1.2	Yes 2 No
20	with th		10e. Street and Number 312 Main Street, Apt. A 21861		10g. Citizen of What Country?	
M	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No	USA 14. Race - American Indi	an,
920	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 Is marked other then "natural", or items 23a or 28a-f show other traumatic event, I'm Meulcal Experiment cash be inclined.	by	1 Never Married 2 Married 3 Widowed 4 Divorced Ammed Porces? 1 XYes 2 No 1942 - If Yes, specify Cuban, Mexican, Pt 1945 1 Yes, Sine Yes, Sine Yes, Sine Yes, Sine Yes or Dates: 1946	derito Fricari, etc.)	Black, White, etc. Specify: Whit	:e
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Industry	
21215-0036	within liene r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker		US Postal Servi	ce
P	al Hyg al Hyg t othe	BeC		Name (First, Middle	, Maiden Sumame)	
yla	r Ment r Ment rarkec	卢		Chamber		
Maryland	id 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relationship (Type, Print) Roland Quenneville/Son 19b. Mailing Address (Street and Number or 312 Main Street, Apt			
re,	is 1 and Heal of Heal Item 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Town, Sta	
altimore,	Page ment c tant: If		'4 Donation 5 Other (Specify) Crematory of Delmarva 4/	23/2005	Delmar, Delawar	e
Ball	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then any Injury or other traumatic event, Item Mones.	,	21. Signature of Fuheral Service Licrosee 22. Name and Address of Facility Zeller Funeral Ho 106 Main Street,	ome, P. O. East New	Box 207	81
	1411		234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		rrest, Appro	ximate al Between
	Physician '		Immediate Cause (Final disease or condition resulting in death) a. Acute lind Failure		Onset	and Death
	/Medical Examiner		Due to (or as a consequence of):			
	pe is	ner	Esquentially list or difficile, if any, leading to immediate cause. Enter Undertying			
	e be executed rsician and e burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760,	te be e ysiciar ie buriè	<u>_</u>	d			
. 68	artifica ing ph e as th	Medi	IF FEMALE:			- 0
Вох	leath certificate l attending physi I for use as the b	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day	Year
P.O.	that the de ted by the a detached t	hysi	9 ☐ Unknown			
	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to the caus Yes 2 □ No 3 ☑ Probably	
COL	s beer 2 shou	plete		24a. Was		lings available
- Re	The lav	Completed		autor perfo	prior to completion death? 2 \[\text{No} \] 1 \[\text{Yes} \] 2 \[\text{No} \]	
Vita	iclan: certific	Be	examiner?	Death (Check only o		
o	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Specify) how injury occurred	
ion	ending Faath. or: After he funera	atlo	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records,	I or Attendl after death. Director: A	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Number or Rural Route wn, State)	Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the pass of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the courred at the time,	cause(s) and manner as stated. date and place, and due to the ca	use(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of centifier 29c. License number		29d. Date signed (Month, Day, Ye	
	F > F 0		D. Blu / MD P16559		04/21/2000	5
			30. Name and address of perso ause of death (Item 23a) (Type, Print)	<i>t</i> - T	1	
	Sta	te	31. Date filed (Month, Day Year) 1 27 South Green Street	t Bal	to, MD	
	Regist		31. Date filed (Month, Appear) 6 200532. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend, item 8 per th 8843 5-31-05 vt

		1 - For State Registrar	State of Mary	•	rtificate of	Death	Re	g. No.	05	1561
Physic	ian	Decedent's Name (First, Middle,					Date of Deat Month	h Day	Year	3. Time of Death
/Med		BERNARD STAN	IISLAUS RAFFEI	RTY			IAY	3	2005	2:20 A
Exami	ner	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County		
		CUMBERLAND NI		a come da a é fainte de col	CUMBERL If Under 1 Year		0. Data of ETHO		EGANY	
Funeral Director	3	217 10 6108	3. Sex 1 M 2 □ F 7. Age (III 93	n yrs. last birthday) Yrs.	Months Days		8. Date of Bits (Month, Day, NOV 11	Year) 1911		elace (State or Forei atry) YLAND
laryland show		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limit
Ba-1 s	cto	MARYLAND ALLEGA	ANY	FROSTBURG	7					1 X Yes 2 □ N
or 2	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of	What Cour	ntry?
ath v	ia	38 McCULLOI		110	215			U.S.		
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "netural", or items 23e or 28e-f show other traumetic event, the Marylan Examiner must be notified at	by Funeral	Narital Status Never Married 2 Marrie Midowed 4 ☑ Divorced	12. Was Decedent Eve Armed Forces? d 1∑Yes 2 ☐ No If Yes, Give Year or Dates:	į	was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spec an, Mexican, Puerto F Specify:	Rican, etc.)		ce - Americ ck, White, y: WHI	etc.
2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occur	pation		16b. Kind of B		
within 7; ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of workin d)	19		TEXTI	LE
d with	ĕ	12	Conego (, 40. 0.)		LABORER			CELAN	ESE	
S should be filed within and Mental Hygiene. is marked other than aumetic event, the M	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	(First, Middle, M	Maiden Sumar	ne)	
uld b Ments rked	2	CHARLES P. RAF	FERTY, SR.			ANASTASI	A SCALL	Y		
2 should land and Menis marke		19a. Informant's Name/Relationsh	p (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town,	State, Zip	Code)
and 2 ealth m 27 in		CECELIA AMAN / I	AUGHTER	723	BEDFORD	ST., CUMBE	RLAND.	MD 215	02	
		20a. Method of Disposition 1 XBurial 2 Cremation		20b. Place of Dispo cemetery, crea	osition (Name of matory or other pla		ate 2	20c. Location	City or To	wn, State
permit. Pages Department of I Important: If its any injury or o	Н	' 4 □Donation 5 □Other (Sp	ecify)	ROCKY GAF	VETERAN	S CEM 5/5/	05	FLINTS'	TONE,	MD
permit. Pag Department Important: any injury once.		21. Signature of Funeral Service L	censee	/	2. Name and Addre			60 W. 1		
Dep imp	-	> 1 (auloy)	1. Xewer		WERS FUN	ERAL HOME,	P.A.	FROSTB	URG,	MD 21532
Pnysician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final.	omplications that caused the nly one cause on each line. Athero So		•	ng, such as cardiac or VUSWU				Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a co		Course	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	, 03.70	nrc -		2 years
LAGIIIIIO	<u>.</u>	Sequentially list conditions,	b. — Sne to (vras a c	intra income offe					-	
ed isit	Examiner	Sequentially list conditions, I ally, Leading to in mediate cause. Enter Underlying Cause (Disease or injury	12031010 3400	a resignor necrosys.						
and Ftran	хап	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
cate be executed physician and the burial-transit										
ficate physis the	edical		d						10	
- O 0		IF FEMALE:	23c. If yes, outcome of p	pregnancy				23d Da	te of delive	in/
eath cer attendin I for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	/		1	onth	Day Year
the d	iysle	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown							
that the de led by the a detached f	H-	Part II. Other significant condition	s contributing to death but n	at resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
uires tha signed I Id be det	d by	Chronic	obstructiv	e puls	nonary	Wrease	1 □ Ye	s 2 🗆 No	3 Prob	abiy 4 Unknow
w requii	Completed				J		24a. Was ar	24h	Were autor	psy findings available
he lav	Ę,						autopsy	/	prior to cor death?	npletion of cause of
icien: Th certificate rector, pag		OC 1Man area referred to madical							1 🗌 Yes	21 X No
siciel certii recto	Be	25. Was case referred to medical examiner?	Hospital:	• C 50/0 · · ·	Ott	26. Place of Death				
Phys this ral dii	2	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier	II 3LI DUA	4 / I Nursing Hom	8d. Describe ho			")
ding h. Afte fune	tor	1 Natural 5 ☐ Pending	(Month, Day Ye	ear) Injury	Wor	k? Yes 2 □ No		, ,		
Attan deat ctor:	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of Injury				8f. Location (Str		er or Rura	I Route Number,
urs after rat Dira	Certification:	4 - Hornicide	building, etc. (S				City or Town			
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of m xaminer: On the basis of ex- and manner stated	amination and/or in	h occurred at the til vestigation, in my o	ne, date and place, as ppinion, death occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	anner as st and due to	ated. the cause(s)
To the Touth	ž	29b. Signature and title of certifier	001	110	29c. Licens		29	d. Date signe	d (Month, I	Day, Year)
	-	worker	asm	140	00	055325		May	04	2005
3+1		30. Name and address of person w	the completed cause of death	h (Item 23a) (Type,	Print)	Frestbur	g MD			
	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	_		U	THE WATER		
Regis	rar	MAY 0	9 2005 Slave	, K	meles	-				
HMH 17 Rev 1/	2001			-						

			1 - For State of Marylar Registrar		artment of H			iene	15 15010
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) Ray Dand Ri 4a. Facility Name (If not institution, give street and number) Copper Ridge	184	4b. City, Town, or	Location of Death	2. Date of Deat Month	Day 2005 4c. County of E	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 219–01–9077	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March Day	5, 1919 P	Birthplace (State or Foreign ENNSYLVANIA
at yiailid Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: or Items 23a or 28e-f ehow Importent: If item 27 is marked other then "netural", or Items 23a or 28e-f ehow eny injury or other treumatic event, the Modical Examiner must be notified at once.	Funeral Director	10a. State 10b. County 10c. Cir MARYLAND CARROLL WE 10e. Street and Number 8 PINE HILL DRIVE	ty, Town or Lo	TER 10f. Zip Code 2115			Og. Citizen of Wha	TATES
13-0030 n 72 hours after de	"netural", or Item edical Exeminer	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)	16a. Dece	Was Decedent of Hi If Yes, specify Cuba 1 Yes X No dent's Usual Occupa kind of work done c DO NOT use retired	Specify:			American Indian, Vhite, etc. WHITE ess/Industry
Id be filed within	ental Hygiene. ked other then ic event, II.e M	To Be Completed	College (1-4or 5+) 17. Father's Name (First, Middle, Last) NORMAN ERNEST RILEY	I .	ICE PRESI	DENT/SALE		faiden Sumame)	RODUCTS
OIE, MAIY	t of Health and M If item 27 is mar or other treumat	-	X Burial 2 ☐ Cremation 3 ☐ Removal from State	8 PII	ng Address (Street a NE HILL D sition (Name of matory or other place	RIVE, WE	STMINSTE	ER, MD 2	or Town, State
permit. Pages	Department Importent: eny injury o		21. Signature of Euneral Service Licensee **Museum A. Museum A.	22 M	ER CEMETE Name and Addres YERS-DURO UTLLIS	s of Facility BRAW FUNE STREET	RAL HOME WESTMIN	E.P.A. ISTER. MO	TER, MARYLAND
E:	nysician Medical xaminer	Examiner	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flarly leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ser the mode of dying Sups GRC d			st,	Approximate Interval Between Onset and Death 2 4275
The law requires that the death certificate be executed	rthe attending physician and ched for use as the burial-transit	hysiclan/Medical Exa	Due to (or as a consequence of the consequence of	ancy	Ectopic pregnancy			23d. Date of Month	delivery Day Year
e law requires that the	has been signed by the attendin le 2 should be detached for use	ompleted by Phy	9 Unknown Part II. Other significant conditions contributing to death but not res diabetes mellitus card Uninary retention	ulting in the ur	nderlying cause give	on in Part I.	1 Yes	24b. Were	e to the cause of death? Probably 4
Physicien:	this certific al director,	To Be C	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 V Nursing Hor	(Check only one	No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	′es 2□No
pitel or Atten	within 24 hours after death. To the Sunerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification)	y) 	eet, factory, office	1	City or Town,	State)	Rural Route Number,
		Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knot on the basis of examina and manner stated. 29b. Signature and title of certifier (Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	wieuge, death	vestigation, in my op	inion, death occurre	ed at the time, da	te and place, and o d. Date signed (Mo	due to the cause(s)
V	IOTIVA		30. Name and address of berson who completed cause of death (Item John C. Apel MD 295 Store	er Ave			minister	- , MO	21187
¢	Sta Registr	*	31. Date filed (Month, Day, Year) 32. Registrar's Signa APR 2 5 2005	ture	Course)				

DAVID RILEY

RAY

			1 - For State Registrar	State of Maryl	and / Depa		t of H	ealth and	d Mental Hy		2005	15619
	Physici	an	Decedent's Name (First, Middle, Last)	Tit.73 10 10	- 41				2. Date of D Month	eath Da	y Year	3. Time of Death
	/Media Examir	cal	4a. Facility Name (If not institution, give stri	EDWARD	BENNETT	4b. City, 7		Location of Do	APRIL	21,		
	Funeral Director		5. Social Security Number 6. Sex 215 – 28 – 3111	2 🗆 🗉	yrs. last birthday) 74 Yrs.	If Under Months		If Under 24 h	1rs. 8. Date of Bi lin. (Month, D 9 / 7 / 1	ay, Year)	9. Birth	place (State or Foreign intry) YLAND
	Maryland I-f show	tor	Usual Residence of Decedent		. City, Town or Lo							10d. Inside City Limits
	th with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 521 MARK DR.			10f. Zip	Code 1157	7			izen of What Cou	ntry?
9800	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show clost Examinar must be notified at	5	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever Armed Forces? 1 ÄYes 2 □ NoK(If Yes, Give Year or Dates: COI	OREAN "	Vas Decede Yes, speci		spanic Origin? , Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: W.F.	
Maryland 21215-0036	d within giene. ir than "	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12		life. L	ent's Usual kind of work OONOT use SHOP	k done di e retired)	uring most of	working		ind of Business/Ir ${ m TE}$ ${ m OF}$ ${ m N}$	ndustry MARYLAND
ryland	should be filed and Mental Hygis markad othar umatic avant, II	To Be (ard Gray				Grac	Name (First, Middle Ce Coope	er		
	nd 2 salth ar	1 3	19a. Informant's Name/Relationship (Type) AGNES RUSH - W	IFE	19b. Mailin 521				Rural Route Numb			
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	b. Place of Dispos cemetery, crem	atory or oth	her place		Date 25/05		cation - City or T	
Balti	permit. Pag Department Important: I any injury o		21. Fignature Fundad Service Licensee		22.	Name and	Address	of Facility F	LETCHER	FUI	VERAL H	•
	Enysician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or healt faillife. List only one immediate Cause (Final disease or condition resulting in death)	clons that caused the deause on each line. 2 wd	eath. Do not ente	r the mode	of dying	, such as card	iac or respiratory a	rrest,	2	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and d for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-								
P.O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pre 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3 🔲	Ectopic pre Other (spe				2	23d. Date of delive Month	ery Day Year
	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contrit	outing to death but not	resulting in the un	derlying car	use giver	in Part I.				he cause of death?
Vital Records,		Completed							24a. Was auto perfo 1 \(\text{Yes}	osy ormed?	24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
Zi.	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: 1 ☐ Inpatient 2	P ☐ ER/Outpatient	3□ 004			leath (Check only of Home 5 X Resi		G01 (0	
ion of	ding Ph n. After th funeral	atlon; T	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of		c. Injury a Work?	at	28d. Describe			0
Division	p af in in	Certification;	4 Holinicide	28e. Place of Injury - A building, etc. <i>(Spe</i>	ecity)				City or To	vn, State)		
	To the Hospital or within 24 hours after To the Funaral Direction completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	an: To the best of my last on the basis of exame and manner stated.	knowledge, death ination and/or inve	occurred at estigation, i	t the time in my opir	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as si place, and due to	ated. the cause(s)
)	.01	Me	29b. Signature and title of certifier	2	7	29c.	License	number A	us !	29d. Date	signed (Month,	Day, Year)
	WILLA	-	30. Name and address of person who comp	leted cause of death (I		rint) f7 (Ba	or n	den st	w	est ment	the MAD
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 5 2[32. Regionar's Sig	gnature							DOLY V

			For State Registrar amend item. 1. Decedent's Name (First, Middle, Last,	8 PER						2. [Re Date of Death	eg. No.2 0 0 (3. Time o	
	Physici /Medic Examin	al	HELEN MARI 4a. Facility Name (II not institution, give Citizens Nursing	street and nun				own, or deri	Location o		ril 2	4c. County of De	eath	Ам
	Funeral Director		5. Social Security Number 244-24-3033 15 Usual Residence of Decedent	M 217F	7. Age (In yrs. I	ast birthday) 9 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. Ju.	Date of Birth Month, Day, Ly 19,	79 25 9. Е 1979 Nor	irthplace (State Country) th Caro	or Foreign lina
	ne Maryland 8a-f show	Director	10a. State 10b. County Maryland , Frederic	:k	-	o,Town or Lo	k						Λ	City Limits s 2 \(\text{No} \)
	with the	Dire	10e. Street and Number 1900 Rosemont Aver	nue			10f. Zip	2170	12		10	og. Citizen of What U.S.A		
36	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Jical Eva , Item must be neilliad at	by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced		2 ₽ № ′e	1	1	ent of His fy Cubar		gin? (Specify , Puerto Rica	Yes or No- an, etc.)		merican Indian,	
Maryland 21215-0036	d within 72 hours after death with the Marylan jiene. jiene. then *naturel; or items 23e or 28e-f show the Masical Exertical must be notified at	Completed b	15. Decedent's Edu (Specify only highest grad	cation		(Give life.	dent's Usual kind of work DO NOT use Omema	k done d e retired)	tion uring most	of working	•	16b. Kind of Busine	b. Kind of Business/Industry	
12	filed w Hygier other th		17. Father's Name (First, Middle, Last)			F	Omema		18. Mothe	r's Name (Fi	rst, Middle, N	Maiden Surname)	ie	
ryland	be de la la la la la la la la la la la la la	To Be	Gurney L. Michael 19a. Informant's Name/Relationship (7)	une Print)		19h Mailir	ng Address		Anna	a Eliz	abeth	Pegram Da		
Ma	0 - 0		Bruce L. Reeder (F		-in-law							, Marylan		
Baltimore,	0 0		20a. Method of Disposition 1		State C	lace of Dispo emetery, crer eland	natory or ot	her place		Date . 4/28		owson, Ma		
Baltii	permit. F Departme Importer any injur													
	rhysician /Medical Examiner		23a. Part . Inter the disease or comp shock, a heart faiture. List only of Immediate Cause (Final disease or condition resulting in death)	a	aused e death agh life (or as a consequ	n. Do not ent	er the mode	of dying	, such as	cardiac or re	spiratory arre		Approxima Interval Be Onset and	etween
8760,	ate be executed hysician and the burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	or as a consequ									
O. Box 6	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna birth 2 ☐ Fetal nant at time of de own	Idéath 3[Ectopic pre Other (spe					23d. Date of of Month	delivery Day	Year
ecords, P.	quires that the signed by and be detacted	by	Part II. Other significant conditions co	ntributing to de	eath but not resu	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	oacco use contribute	to the cause of Probably 4	
α		Completed					_				24a. Was an autops perform	y prior :	autopsy findings o completion of ? es 2 \(\square\) No	available cause of
Vital	sicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Lannitak				Out.		_	heck only on			
of	Phys r this ral di	on: To	1 ☐ Yes 2 ☑ No 27. Manner eath 1		Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time o Injury	1 28	Bc. Injury Work	at	28d.		nce 6 □Other (S w injury occurred	pecify)	
Division	or Atteno after death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace buildi	of Injury - At ho ing, etc. <i>(Specif</i>)	ome, farm, str y)	M reet, factory	-	/es 2 □ I		Location (Sti City or Town	reet and Number or n, State)	Rural Route Nui	mber,
_	To the Hospital within 24 hours and the Funeral completely filled	edical C	29a. Certifier (Check only one)	iner: On the b								ause(s) and manner ate and place, and c		(s)
	To the within To the	Me	29b. Signature and title of certifier	10/1	of the	Har	290	. License	number	83		9d. Date signed (Mo		200
•	7		30. Name and address of person who s	ompleted caus	se of death (Item	23a) (Type,	Print)	th	57	FIR	do	april's	NO	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6	2005 ^{32. F}	strar's Signa	iture	Soul	,3						

05-2944 B.K.S

PAT.

ΊE	SMITH		State 1 - State Unpend Item 23a&27	of Maryland / Dep. per me G843	artment of Health and -11-05 tas rtificate of Death	Mental Hygie	ene) 05	15621				
	Physici	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
	/Medi	cal		ti L. Smith	1 4 6 7	APRIL 28	, 2005	1338 P M				
	Examir	ner	4a. Facility Name (If not institution, give street and 9419 COLLETTE WAY	number)	4b. City, Town, or Location of Dea GAITHERSBURG	ath	4c. County of Death MONTGOMER					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr			place (State or Foreign intry)				
	Director		217-74-7706 1□M 2⊠	41 Yrs.	Months Days Hours Mir	July 9,	1963 Wash	ington D.C				
1	and a		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits				
100	Many Fled	ţō	Maryland Montgomery	Montgome	ry Village			1⊠Yes 2□No				
i d	07 28g	lrec	10e. Street and Number	22020	10f. Zip Code	100	. Citizen of What Cou	intry?				
4	23a v	ral	9419 Collette Way		20886		Jnited Star	tes				
1	is 1 and 2 should be filed within 72 hours eller death with the maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other then "natural; or Itams 23s or 28s-f show other traumatic event, Ita Madigal Exantitic must be invitiled at	Funeral Directo	Arme	Decedent Ever in U.S. 13. 15 Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White					
Z 1 Z 1 Z - 0000	al', or	þ	If Yes	Give Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite				
	natur	Completed	15. Decedent's Education (Specify only highest grade complete	16a. Dece	dent's Usual Occupation skind of work done during most of w	orking 16	6b. Kind of Business/Ir					
7	12 should be tiled within h and Mental Hygiene. 7 is marked other than " raumatic event, the Mad	mple	Elementary/Secondary (0-12) Collect	life.	DO NOT use retired)	orking	_					
1	Hygie Hygie ther ti		12 17. Father's Name (First, Middle, Last)		Homemaker 18 Mother's No	ame (First, Middle, Ma	Own Hor	ne				
Ivial y land	d be ental ked o	To Be	James W. Smith			B. Corbin	iden Sumame/					
al y	and M mar umati	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Number or F		City or Town, State, Zi	o Code)				
- ;	of Health of Health is item 27 li		James W. Smith Jr./Bro	ther 5992	Heron Pond Drive	. Port Ora	nge, Flori	ida 32128				
5	of He	ľ	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal fi	20b. Place of Dispo	osition (Name of		c. Location - City or T					
alumore,	permit. Pages Department of Importent: If i any injury or o	l d	* 4 ☐ Donation 5 ☐ Other (Specify)	Metropol	itan Crematoriun		lexandria,	Virginia				
	permit. Departr Importe any inju		21. Signature of Edneral Service Licensee		2. Name and Address of Facility Lin L. Molesworth 5401 Ridge Road,	P. A. Fur	neral Home					
		-	23a. Part1. Enter the disease, or complications the	at caused the death. Do not en	ter the mode of dving, such as cardi	Damascus,	Maryland 2	20872 Approximate				
	hysician		shock, or heart failure. List only one dause	on each line.			• •	Interval Between Onset and Death				
	/Medical			teriosclerotic to (or as a consequence of):	cardiovascular d	ısease						
Ε	Examiner		Sequentially list conditions b.									
7	sit s	lner	if any, leading to immediate Due to (or as a consequence of):									
	ate be executed hysicien and the burial-transit	Examin	Cause (Disease or intry that initiated events resulting in death) Last Due to (or as a consequence of):									
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פֿ כ	cernicate nding physi use as the l	Ø.										
Y		Completed by Physician/M		outcome of pregnancy ve birth 2 Tetal death 3 (Ectopic pregnancy		23d. Date of deliv	,				
. 7	the attenthed for n	SICI	1 ☐ Yes 2 ☐ No 4 ☐ P	regnant at time of death 5 [Other (specify)		Month	Day Year				
)	w requires that the death been signed by the atte should be detached for	Ph)	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause given in Part I	23e Did tobar	cco use contribute to t	he cause of death?				
ה ה ה	signe signe	d by			and onlying oddso given are are.			bably 4 Unknown				
or vital necolus,	as beer 2 shou	lete				24a. Was an	24h Were auto	opsy findings available				
ב ב	0 5 0	ошо				autopsy performe	prior to co death?	impletion of cause of				
2	certificate ector, pag	BeC	25. Was case referred to medical		26. Place of De	eath Check on one	No 1 ☐ Yes	2 □ No				
	S	ို		☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 Residence	ce XXIOther (Specia	AT SCENE				
		on:	i Latinai	ate of Injury 28b. Time of Injury Injury	Work?	28d. Describe how	injury occurred					
DIVISION	Attending r death. ector: After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At home, farm, st	M 1 Tyes 2 No	29f Location (Stro.	et and Number or Run	al Clauda Alumbas				
= 3	etter Direct	ertif	4 Homicide determined b	uilding, etc. (Specify)	теві, тастоту, опісе	City or Town,	State)	ar noute ivumber,				
	l o the Hospitel or Attenswithin 24 hours etter deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, deat	th occurred at the time, date and place	ce, and due to the caus	se(s) and manner as s	stated.				
3	in 24 in 24 in Pu	edical	(Check only 2 Medical Examiner: On the cone) and the cone one of the cone of t	ne basis of examination and/or in nanner stated.	evestigation, in my opinion, death occ	curred at the time, date	and place, and due t	o the cause(s)				
	within 24	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, L									
Test Cay							APRIL 29,	2005				
			30. Name and address of person who ampleted	ause of death (Item 23a) (Type,	.Print) N STREET, BALTIMO	TRE MADVI AT	VID 21201					
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	N OTREET DALITIN	JAE, MAKYLAI	אט אדאטד					
	Regist		MAY 0 9 2005		hank a							
DHM	IH 17 Rev 1/2	2001	0 0 2003	Blown It of	Marie Contraction of the Contrac							
				ORIGIN	AL							

			1 - For State Registrar	State of Marylar		artmen rtificat				Reg. No.	005	15622
ı	Physici	an	Decedent's Name (First, Middle, Last Edward Edward Figure 1					. 	2. Date of De	Day	Year	3. Time of Death
	/Media		Edward 4a. Facility Name (If not institution, give	Lee		shele		L L Location of Dea	100	26	ounty of Death	11
1	Examir	ıer	Howard Couchy Gener			1		, MD	เก		toward	
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under	1 Year	If Under 24 Hrs				place (State or Foreign
п	Director		230-84-5055	^{3 M 2□ F} 56	Yrs.	Months	Days	Hours Min	January		Cou	shington D.
	pu »		Usual Residence of Decedent 10a. State 10b. County	1100 5	ity, Town or Lo							
	shov	5				cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Directo	Maryland Howard 10e. Street and Number	Lat	ırel	10f. Zip	Codo			10- Citi	n of What Cou	
	with	2					723			U.S.		intry :
	Jeath	Funeral	8455 Murphy Road	12. Was Decedent Ever in U	J.S. 13.			spanic Origin? (Specify Yes or No		. Race - Ameri	ican Indian.
9	after or ther	교	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No					Specify Yes or No to Rican, etc.)	į	Black, White	, etc.
8	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2KI No	Specify:		S	^{рөсіfу:} Cau	casian
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show na M. alcal Examicer Lust be rectified at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dece (Give	dent's Usua kind of wo	al Occupa	ition uring most of wo	orking	16b. Kind	of Business/Ir	ndustry
121	within ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)						DT A		
	Hygie Hygie other ant. II		17. Father's Name (First, Middle, Last)		Hand	icapp	ea	18. Mother's Na	me (First, Middle	NA Maiden Si	umame)	
an	ould be Mental larked o	To Be	Edward Lee Sheley,	Tr				Jean Fu		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Maryland	2 should I and Meni is marker	F	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address	(Street a		ural Route Numb	er, City or 1	Town, State, Zij	p Code)
	1 and 2 Health a em 27 is ther trau		William R. Sheley	- Brother	1				exandria			,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any njury or other traumatic svent. The Modical Examination is stalled at 2008.		20a. Method of Disposition	20b.	Place of Dispo cemetery, crer	sition (Nar	me of other place	9)	Date	20c. Loca	ation - City or T	own, State
Ē	Pages nent of I int: If it	١.	1 ☐ Burial 2 X Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,		tropoli					A1e	xandria	a. VA
alti	permit. Pag Department Important: I any Injury o	!	21. Signature of Funeral Service Licens						Jefferson			
_	8858		Kobest	> Evan	<u>)</u> 5	755 C	ast1		Dr. Alex			•
	Physician /Medical Examiner	iner	23a. Part1. finiter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ne cause on each line. a. Pulseluss (Due to (or as a consect Due to	Plechic quence of): fruia quence of):		tità	who		rrest,		Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burist-transit	//Medical Examiner	resulting in death) Last	Due to (or as a consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consect of consec	ancy					22.	d. Date of deliv	004
o.	that the death	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pr Other (sp				2740172	Month	Day Year
rds, P	w requires that been signed to should be det	b	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying o	ause give	n in Part I.	23e. Did t			the cause of death?
al Records,	ilclan: The law racertificate has be rector, page 2 sh	Completed			-				24a. Was autor perfo 1 \square Yes		24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Vital	Physiclan: this certificatal director,	Be C	25. Was case referred to medical examiner?	Hospital:	/		Othe	-	ath Check on c			
of	Phys r this sral di	- L	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time of		JA	4 Nursing	Home 5 Resident			fy)
on	th. : After s funer	tior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	28c. Injury Work 1 ☐ Y	? ′es 2 ∐ No		,,		
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, str ify)	eet, factory	y, office		28f. Location (City or Tox		Number or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dirac completely filled in I	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred vestigation	at the time, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			290	c. License	number		29d. Date s	signed (Month,	Day, Year)
			Duch	MD.			Do	58206		4-2	27-05	
			30. Name and address of person who concerns the second court is 31. Date filed (Month, Day, Year)	ompleted causer of death (Ite	m 23a) (Type,	Print)	C	lenbig,	MD 216	346		
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 0 201	100 h	ature do	de				A		

			For State Registrer	State of I	Marylan		artmen rtificat				•	giene Reg. No:	005	156	23
	Physici	an	1. Decedent's Name (First, Midd.	le, Last)							2. Date of De. Month	ath Day	Year	3. Time of	
	/Medic		Raymond Sin								April	21	2005	8:53	Рм
7	Examin	er	4a. Facility Name (If not institution	•					Location o	of Death			County of Death		
	Funeral		Washington Adv 5. Social Security Number		Age (In yrs. I	ast birthday)	If Under		Park If Under	24 Hrs.	8. Date of Birt		ontgome 1		r Foreian
	Director		579-50-3575 Usual Residence of Decedent	1 ⊠ M 2□F	66	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da JAn• 13	y, Year) 193	9 Wash	place (State of untry) ington	D.C
	Maryland	tor	D · C ·	,		, Town or Lo Ishingt								10d. Inside Ci 1 🏝 Yes	•
	h with the 23a or 28	al Director	10e. Street and Number 1221 M Street	N.W. #907			10f. Zip 20	Code 005		-		10g. Citiz	en of What Co	intry?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23s or 23s-f show other traumatic event, the Madical Extenine requires natified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	WVac Give	is? ⊒ No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: B1a	, etc.	
Maryland 21215-0036	within 72 ho iene. than "natur ing Madicell	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 1 2 th .	nt's Education st grade completed) College (1-4c	or 5+)	(Give life.	dent's Usua kind of wor DO NOT us odian	k done d e retired	lu <i>rina</i> mosi	t of work	ing	16b. Kin	church		
rland 2	2 should be filed and Mental Hygid Is markad othar raumatic event, III	To Be Co	17. Father's Name (First, Middle, Edward Sims	Last)							e (First, Middle,	Maiden S			
	nd 2 shoulth and N 27 Is ma		19a. Informant's Name/Relations Claudine Sims			1	-						Town, State, Z.		
Baltimore,	Pages 1 and 2 nent of Health Int: If item 27 I ury or other tre		20a. Method of Disposition 1 □ Burial 2 🛱 Cremation 1 □ Donation 5 □ Other (S		· CE	lace of Dispo emetery, crei	natory or o	ne of ther place		-25-	Oate 05		ation - City or 1 andria,		
Balti	permit. Pages : Department of F Important: If ite any injury or ot once.		21. Signature of Funeral Service	Licensee Nauhal	l								eral Ho D.C. 2		
}	Physician		23a. Pary . Inter the disease, o shock or heart failure. List Immediate Cause (Final disease or condition	r complications that cause only one cause on each	ı line.	ſ	er the mode		g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Bety Onset and E	veen
	/Medical Examiner		resulting in death) Sequentially list conditions,	b	as a consequ										
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on of	ding After fune	ion: To	27. Manner of Death 1 Natural 5 Pendi	28a. Date of II (Month, I		28b. Time of Injury		Bc. Injury Work	4 🗆 140	:	28d. Describe h		Other (Specioccurred	ny)	
Division	or Atten after deal Diractor, in by the	ertification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At horests. (Specify	me, farm, str					28f. Location (S City or Tox	Street and vn, State)	Number or Rui	a <i>l R</i> oute <i>Num</i> t	oer,
	ne Hospital n 24 hours a na Funaral bletely filled	edicai C	29a. Certifier (Check only one) Certifying 2 Medicel	ng Physicien: To the be Exeminer: On the basis and manner	of examinat	wledge, death ion and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
•	To the I within 2: To the I complet	M	29b. Signature and title of certifie	Kennely I	Thef	1, 1.1	// //	License		6			signed (Month)		
21	3)		30. Name and address of person												
	Sta Registr	_	JAmes Kenned 31. Date filed (Month, Day, Year, APR 2 6	y Lightfoot 2005	Jr strar's Signat	M.D. 7	600 (Garro	11 A	ve.	<u>Fakoma</u>	PArk	, MD.		
	negisti	ai .	MINAU	- Judge	(C.)	147	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April 23, **Physician** 9:30 p LOIS NANCY SPENCER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV. 7, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F Washington 82 1922 Director 532-20-4802 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Modical Examiner: ust be notified at 1 XYes 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8515 Springvale Terrace 20910 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No 1945-tf Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Accountant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should ba fill and Mental H Mary Johnson Reuben Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Spence R. Spencer - Son 6605 Powhatan Street, Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 5/18/2005 Arlington, Virginia 21. Signature of Funéral Service Ligense 22. Name and Address of Facility Gasch's Funeral Home, P.A. Mal 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complexitions, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 96 PHCEMIA /Medical Due to (or as a Insequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has b page certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To tha Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 42936 APRIL 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VARNUM ST. WASHINGTON D.C. 20017 5705 R. 31. Date filed (Month, Day, Year) . Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 2 6 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	For State Registrar	State of	Maryland / De	partme ertifica			nd Mental	Hygiei	_ U U U	5625
	Physici	an	1. Decedent's Name (First, Middle						2. Date April	of Death	Day 2005 Year	3. Time of Death
	/Medic Examin		Bernard L. St 4a. Facility Name (If not institution, I 495 @ Woodrow				Town, or	Location of ille	1 -	Ť	4c. County of Death Prince Geo	1
	Funeral Director		577-08-5754	6. Sex 7. 1 🖾 M 2 🗆 F	Age (In yrs. last birthd	Months	Days	If Under 24 Hours	Min. (Mor	of Birth oth, Day, Ye	ar) Coi	nplace (State or Foreign unity)
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County VA •		10c. City, Town o							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-f	irect	10e. Street and Number		Alexa		p Code	·· <u>·</u>		10g.	Citizen of What Co	
960	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	7101 Mint Place 11. Marital Status 1 X Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force	es? ☑No	3. Was Deci	ocity Cuba	ispanic Origin, Mexican, I	n? (Specify Yes Puerto Rican, e	or No-	USA 14. Race - Ameri Black, White	e, etc.
1215-0	within 72 ho ene. than "natu he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		(G	ecedent's Usitive kind of wife. DO NOT	ork done o	durina most c	of working	16b	. Kind of Business/I	ndustry
Maryland 21215-0036	d 2 should be filed within "h and Mental Hygiene." 7 is marked other than "I raumatic event, the Mec	Be	12th. 17. Father's Name (First, Middle, L	ast)		Oriver			s Name (First, I	Middle, Maid		y Cleaners
aryla	should and Me smark sumation	Ţ	Walter Steen 19a. Informant's Name/Relationsh	ip (Type, Print)	19b. M	ailing Addres	s (Street		Ann Dixe		ry or Town, State, Z	ip Code)
	1 and 2 Health : em 27 I		Walter Steen/	Father	2619 20b. Place of D			Ave. 7	204 Ter		Hills, Md	
Mor	Pages ient of I nt: If ite		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp		anmoton.	crematory`or	other plac				ndover, M	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic a once.		21. Signature of Funeral Service L			22. Name a	nd Addres	s of Facility	MArsha	11's I	Funeral Ho	ome
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	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. En a Liberturing Cause (Disease or injury	b	as a consequence of):							
8760,	death certificate be executed e attending physician and nd for use as the bunat-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or d.	as a consequence of):							
P.O. Box 68	that the death certifica hed by the attending ph detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death It at time of death	3 ☐ Ectopic 5 ☐ Other (s					23d. Date of deliment	very Day Year
	w requires that the been signed by th should be detache	ed by PI	Part II. Other significant conditio	ns contributing to deat	h but not resulting in th	e underlying	cause giv	en in Part I.	236	. Did tobacc		the cause of death?
Vital Records,	The law ate has b page 2 st	Complet							_	. Was an autopsy performed Yes 2	? prior to c death?	topsy findings available ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpa	tient 3□□	OA Oth		f Death Check		6 ⊠Other (Spec	ity) at scene
ion of	ng (fer		27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of (Month,		e of	28c. Injun Worl	/ at	28d. Des	cribe how in	njury occurred	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At home, farm, etc. (Specify)	, street, facto	ry, office	,			and Number or Rusate) 1495	
	To the Hospital or At Within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the bas and manne	est of my knowledge, d s of examination and/o stated.	eath occurre r investigatio	d at the tin	ne, date and pinion, death	place, and due occurred at the	to the cause	e(s) and manner as and place, and due	stated. to the cause(s)
	To t withi To ti comp	M	29b. Signature and title of certifier	Mi	J.+_	29	OCME				pate signed (Month) il 23, 20	
R	(2)		30. Name and address of perso j		of death (Item 23a) (Ty	pe, Print)	111	Perm S	treet	Balti	more, Mar	yland ZiZUI
	Sta Registr	1.00	31. Date filed (Month, Day, Year) APR 2 6 20		istrar's Signature	ule						

DHMH 17 Rev 1/2001

Registrar

APR 2 6 2005

				State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	-	giene Reg. No.	005	15627					
				1. Decedent's Name (First, Middle, Last)	2. Date of De	ath		3. Time of Death					
		Physici /Medic		KENNETH SCOTTON, JR.	Month Q4	Day	Vear D5	11:53 AM					
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sallsbury		4c. C	Wirom	•					
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month Da 01-12-	th v. Yearl		place (State or Foreign					
		Director		216-64-9350 A Yrs. 52 Yrs.	01-12-	1953	BAINB	RIDGE, MD.					
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits					
		Mary f sho	jo	DE SUSSEX LAUREL				1√2 Yes 2 □ No					
		1 the	Director	10e. Street and Number 10f. Zip Code		10g. Citize	en of What Cour	ntry?					
		3a o	O is	10960 MATT AVENUE 19956			USA						
		ems s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	- 14	1. Race - Americ Black, White,						
	36	or It		1 □ Never Married 2 1 □ Yes 2 1 No If Yes, Give 1 □ Yes 2 1 No Specify:	Thousand Octor)	-		ITE					
	Ö	hours tural';	d by	3 Widowed 4 Divorced Year or Dates:									
	15	in 72 in 72	ojete	15. Decedent's Education (Specify only highest grade completed) If a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind	d of Business/In	dustry					
	21215-0036	yiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 SURVEYOR		POWE	ER COMPA	NY					
	Du	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Modical Exartil et mail by notified at	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name			lumame)						
	yla	Ment Ment arkec	70	KENNETH SCOTTON, SR. NORMA G									
	Maryland	d 2 should be filed within th and Mental Hygiene. 7 Is marked other than "traumatic event, in a Mag		19a. Informant's Name/Relationship (Type, Print) EUNICE SCOTTON-SPOUSE 19b. Mailing Address (Street and Number or Run 19b. Mailing Address (Street and Number or Run 10960 MATT AVENUE, LAUR				Code)					
	e,	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, II a Modical Examilier must be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ation - City or To	own, State					
	io E	pages ent of nt: If it		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 04-2	3-2005		•						
	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	NDS FUN	ERAL	HOME, I	NC.					
	Ö	Pe a F a		Molesso ky feeling 705 EAST MAIN STRE			MARYLA	AND 21804					
				23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,		Approximate Interval Between					
		Physician		mmediate Cause (Final issease or condition equition a. Conset and Death Heart failure Conset and Death									
0		/Medical Examiner		Due to (or as a consequence of):									
35		1500	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):									
0		outed id ansit	Examiner	Cause (Disease or injury that initiated events									
7	ó,	cate ba executed physicien and the burial-transit	Exc	resulting in death) Last Due to (or as a consequence of):									
7-	8760,	ate by	dicai	d									
216	9 X	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			10000						
6	Bo	eath certifii attending p I for use as	cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23	3d. Date of delive Month	Day Year					
2	P.O.	it the de by the tached	Physician/Me	1 Yes 2 No 4 Pregnant at time or death 5 Other (specify) 9 Unknown									
Hon		The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	ьу Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use	e contribute to th	ne cause of death?					
8	ecords,	v require been si				Yes 2□	No 3 ☐ Prob	ably 4 Unknown					
S		e ław r has be je 2 sh	ompleted		24a. Was	psy	prior to co	psy findings available mpletion of cause of					
F	E R		Co		1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No					
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	Division	r Attendi er death. rector: A by the fi	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and i	Number or Rura	I Route Number,					
	Ö	Ital or	Cer										
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	29a. Certifier (Check only one)	and due to the red at the time,	cause(s) a date and p	nd manner as st place, and due to	tated. the cause(s)					
_		To the Within To the	Me	29b. Signature and title of certifier 29c. License number			signed (Month,	Day, Year)					
		08		V 100 D55658		4	/21/0	2005					
		B		30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) FIANK AIRNA M.O. 400 E. Shore DV. 5916	1. 1.1	N	20						
		10	10	31. Date filed (Month, Day, Year) 32. Pigistrar's Signature	13 041	-		-					
		Sta Registi		31. Date filed (Month, Day, Year) APR 2 5 2005 APR 2 5 2005 APR 2 5 2005	V								

			1- For State of Maryland / Department of Health and Certificate of Death		giene eg. No. 005	15628							
	Physici		1. Decedent's Name (First, Middle, Last) Jean H. Sims	2. Date of Dea Month Apr. 20	Day Year	3. Time of Death 1 0 1 0 M							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Death								
			Shady Grove Adventist Hospital - Rockville 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs		Montgom								
	Funeral Director		579-30-1174 1 M 2 X F 76 Yrs. Months Days Hours Min.		, Year) 9. Birth Con Con Wa	place (State or Foreign intry) sh.,DC							
	ow a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
	e-fsh	ctor	Md. Montgomery Rockville			X□Yes 2□No							
	d within 72 hours after death with the Maryland jene. Ir than "netural", or Itama 23a or 28e-f show If a Modeal Examiner must be neitilieu a	Funerai Director	10e. Street and Number 10f. Zip Code 20850	1	Og. Citizen of What Col	intry?							
	er deati itama 2 rer mu	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- rto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.								
9036	ours aft iral', or	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yes, Give 1 □ Yes 2 ② No Specify: Year or Dates:		Specify: W	nite							
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212	filed within I Hygiene. other than "	Com	12 Resident Manager		Aprtment	House							
and	ld be fill ental H ked oth c even	To Be		n Lowe	Maiden Surname)								
Maryland 21215-0036	d 2 should by th and Menta 7 is merked traumatic er	F	19a. Informant's Name/Relationship (Type, Print) Sue Milan- Daughter 19b. Mailing Address (Street and Number or R 12317-Chalford La.	Rural Route Numbe	r, City or Town, State, Z	ip Code)							
	ges 1 and 2 should be filed nt of Health and Mental Hyg If Item 27 is marked othe or other traumatic event,		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or	own, State							
altimore,	permit. Page Department of Important: If any injury or once.		1X Burial 2 Cremation 3 Removal from State Baltimore Nat. Cem. 4/26/2005 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Semi-Vicensee 4/26/2005 Baltimore, Md. 22. Name and Address of Facility Hysong Co., Inc. 6510_16+b_S+_NW_Wash_DC										
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	(/	29d. Date signed (Month	, Day, Year)							
)	5		Willian Sook, MI 13376	5//	4mil2	6,2005							
_	(5)		30. Name and address of person who complete cause of death (It a) (Type, Print) Dr. William Dooley- 9901-Medical Center Dr.	.,Rockv	ille,Md.20	850							
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 5 2005										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Robert Charles Trankley **Physician** 30[°] 2005 1640 РМ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll County 3699 Bert Koontz Road Taneytown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 5, 19 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 217-64-2924 46 Yrs 1958 Pennsylvania **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Heatih and Mental Hygiene.
Item 27 is marked other than "naturel", or items 23e or 28e-f show other treumatic event, Its Medical Exam armust be notified at 1 ☐ Yes 2X No Carroll County Taneytown Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3699 Bert Koontz Road 21787 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cement plant millwright 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annabelle Pitts Edwin R. Trankley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 Is any injury or other treu Lynn M. Tankley / wife 3699 Bert Koontz Road Taneytown, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Md. Smithsburg Crematorium 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytow 21. Signature of Funeral Service Licensee Taneytown, Md. 21787 www Approximate Interval Between Set and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner and Il-transit that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Physician/Medical as IF FEMALE: esu. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? page 2□ No 20 1 Yes Division of Vital director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 🗔 NG 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending after death.
I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 T Homicide vithin 24 hou.
the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) and title of certifier 29c. License number 29b. Signature 30. Name and Westminster, MD 2115 Street Flavio hruter anter 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State Registrar

ORIGINAL

			for State Registra/Amend #5.Per FH	State of Maryland PGC 4-29-05 cm		artment of H		-	giene	15630
ch.	4 +		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic		Dorothy Mae Tru	ieheart		_		April	2, 2005	- 1502M
	Examir		4a. Facility Name (If not institution, give st	1 1	- 1	4b. City, Town, or	Location of Deat	h	4c County of De	ath (
	1		5. Social Security Number 6. Sex		last hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Frince	irthplace (State or Foreign
	Funeral Director			M 2⊠F 58	Yrs.	Months Days	Hours Min.		y, Year)	uth Carolina
	iand ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ţō	Maryland Prince Ge	eorge Cap	itol H	eights				1√2 Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28a-f show other than "natural", or item rutal be maillied at event, it is Madical Examination.	i Director	10e. Street and Number 6604 Valley Park Ro	oad	%.	10f. Zip Code 20743	. • /		10g. Citizen of What (United St	•
	death	Funeral	11. Marital Status 1	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	Specify Yes or No	- 14. Race - An Black, Wh	nerican Indian,
36	or Ite		1 Never Married 2 Married	1 ☐ Yes 21 No If Yes, Give	1	1 ☐ Yes 2 ☑ No		to moun, etc.,		Black
21215-0036	hours tural'	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
215	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	furing most of wo	rking	TOD. Talla of Dashies	ariidusiiy
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pu	2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, It a Men	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Ş	d Men narke	ပ္	James Phillips	an Drintl	10h Maili	- Address (Chronto		Harris		75-0-4-1
Maryland	s 1 and 2 should f Health and Men Item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type Paul M. Trueheart/	•					er, City or Town, State Heights,	
ē,	of Health of Health of Item 27 I		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of matory or other place	e)	Date	20c. Location - City	or Town, State
Baltimore,	Pages ment of I ant: If Its lury or o		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)			emorial C		7/05	Suitland,	Maryland
Balt	permit. Page Department Important: If any injury o		21. Signature of Funeral/Service License	ille	22 A 5	Name and Addres 1exander 538 Marlb	s of Facility S. Pope oro Pike	Funeral e, Fores	Homes tville, MD	20747
г			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.						Approximate Interval Between Onset and Death
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	/Medical Examiner		Tooliting in doutry	Due to (or as a conseq	uence of):					
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90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ate hy:	dica	d							
ox e	death certifica attending phate as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of o	elivery
<u> </u>	death e atte	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0	at the by th	hys	9 🗆 Unknown	9□ Unknown						
	The law requires that the death certific tite has been signed by the attending p page 2 should be detached for use as:	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t		to the cause of death? Probably 4 Junknown
orc	w requir been si should	eted						language.		
Records,	has by ge 2 s	Completed						24a. Was auto perfo		autopsy findings available o completion of cause of ?
Vital		e Co	25. Was case referred to medical				Of Place of Do	1 Yes	2 ☐ No 1 ☐ Y	as 2 No
5	Physician: this certific ral director,	To B	examiner?	ospital: 1 Inpatient 2	ENOutpatie	nt 3 DOA Othe	25	ath <i>(Check only o</i> Home 5 ☐ Resi	dence 6 □Other (St	pecify)
J Of	ਦ ਜੁ≅		27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		/ at		how injury occurred	,
Sioi	Attending r death. ector: After by the fune	catic	2 Accident investigation			M 1 🗆 '	Yes 2 □ No			
Division	I or Attence after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
1	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier 1☐ Certifying Phys	sician: To the best of my kno	wledge, deat	h occurred at the tim	ne, date and place	e, and due to the	cause(s) and manner	as stated.
	n 24 h	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my of	pinion, death occ	urred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	10-		29c. License			29d. Date signed (Mo	nth, Day, Year)
	1		Howard 1	grosto o	9	Hoo	53927	7	Hpril 23	,2005
R	10		30. Name and address of person who co		n 23a) (Туре, Носол	Print)	are CA	Gran 1.	Mrs. 1	and
	St	ate	31. Date filed (Month, Day, Year)	Registrar's Signa	-	10-10-	7	1/	- ing/	74
	Regist		APR 2 6 2005	Red K	has	1. 1				

			1 - For State of Registrar		artment of Health and M rtificate of Death	lental Hygier	2005 1500
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year
	/Media	cal	Ruth Cohn Tepping			April 1	
	Examin	ier	4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Death	1	4c. County of Death
	Funeral			Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Montgomery 9. Birthplace (State or Foreign Country)
	Director		300-07-9124	88 Yrs.	Months Days Hours Min.	December 16	, 1916 Wisconsin
	put		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Aaryië Fehor	ō	Maryland Montgomery	Silver S			1 XYes 2 No
	28a-	rect	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	72 hours after death with the Maryland Inatural; or Items 23a or 28a-f ehow Jigal Examinat must be mailliad at	Funeral Director	401 Apple Grove Road		20904		ited States
	ems deat	ner	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2	IXNo	1 ☐ Yes 2 🖫 No Specify:	Thousi, Story	Specify: White
21215-0036	houn tural	q pa	3 分 Widowed 4 ☐ Divorced Year or Date 15. Decedent's Education		dent's Usual Occupation	16h	
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nd	ba file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	en Surname)
<u>Y</u> a	ould Men narka	J.	Max Cohn		Ida Glu		
Maryland	d 2 sh th and 7 is n traum		19a. Informant's Name/Relationship (Type, Print) Michael Tepping/ Son		ng Address (Street and Number or Run		
<u>ئ</u>	Heali Heali tem 2 Sthar		20a. Method of Disposition	20b. Place of Dispo	Apple Grove Road,	100000000000000000000000000000000000000	ring, MD 20904 Location - City or Town, State
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Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "naturat; or items 23a or 28a-f show any injury—fothar traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen ee	/ Medical C	2. Name and Address of Facility Col P.O. Box 58007	2003	
Ö	P T T S		O Sunt le		P.O. Box 58007	Washingto	on, D.C. 20037
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent h line.		or respiratory arrest,	Approximate Interval Between
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П	/Medical Examiner		resulting in death) Due to (or	as a consequence of):			
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000	aw re	piet				24a. Was an	24b. Were autopsy findings available
Ä		Completed				autopsy performed?	
/ita	clan: ertific ector.	Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
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	ospita hours unera ly tille		29a. Certifier 1 Certifying Physician: To the be	est of my knowledge, deat	h occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours aller death. To the Funeral Director: Atter this certific completely lilled in by the tuneral director.	Aedical	one) and manner	r staled.	vestigation, in my opinion, death occurr		
	with To Con	Σ	29b. Signature and fulle of certifier	(DIME)	29c. License number		Date signed (Month, Day, Year)
	5		200 Name and address	(0.00)			T .
			30. Name and address of person who completed cause CASL 2 (MARGOLD, NO	or death (Item 23a) (Type,	Print) how , Accent	, MO LOSS	C
	Sta	ate		istrar's Signature	ale d	<u> </u>	
	Registi	rar	31. Date filed (Month, Day, Year) APR 2 5 2005	W D. M.			

Gregory Scott Tracy

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State Registrar
DHMH 17 Rev 1/2001

			Please	State of Maryland				•	•	
			1 - For State Registrar	State of Marylant	•	rtificate of De			g. No.? AAS	روام روادر مور دا و
			Decedent's Name (First, Middle, L.)	ast)		Timouto of Be	2.1	Date of Death	n is U W	3. Time of Death
н	Physicia		6	Scott Trac	M			Month	Day Year 21 2005	5:190 M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	7	4b. City, Town, or Lo			4c. County of Deat	
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	Funeral			Sex 7. Age (In yrs. II			Under 24 Hrs. 8. I	Date of Birth (Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry)
	Director		217-08-2634	11X M 2□F 36	Yrs.		4,	/29/196	68 Mary	land
	and .		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	daryl f sho	ō			allsto					1 ☐ Yes 2 🛣 No
	28a-	Director	MD Baltimo 10e. Street and Number	re Kand	allst	10f. Zip Code		10	Og. Citizen of What Co	untry?
	3a or		8624 Allenswood R	d. Randallstown		21133			nited Stat	
	death ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specify		14. Race - Ame	ncan Indian,
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			мехісап, Риепо ніса <i>Specit</i> y:	in, etc.)	Black, White	nite
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121	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Plumb	DO NOT use retired)		1	Blue Dot	
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an	d be ental cad o	To Be	Ronald B. Tracy	,			ace C. Mcl			
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " fraumatic event, the May	Ě	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street and			City or Town, State, Z	ip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural, or Itema 23a or 28a-f show or other traumatic event, the Madical Expressing man burnelitied at		Grace Tracy (mo	ther)	8624	Allenswood	Rd. Randa	allsto	wn, MD 211	33
Je,	of Heil Item		20a. Method of Disposition		lace of Disp	osition (Name of matory or other place)	Date	2	20c. Location - City or	Town, State
E	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	Hemovai from State		Mem Park	4/25/200)5 Sy	kesville,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: if Item 27 ii any injury or othar tra 20028.		21. Signature of Furteral Sorrice Li	ensee /	Bi	2. Name and Address of	of Facility n Funeral	Home a	and Cremat	orv. P.A.
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г			3a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death ly one cause on each line.	n. Do not en	ter the mode of dying, s	such as cardiac or re-	spiratory arre	est,	Approximate Interval Between Onset and Death
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99	leath certificate I attending physi I for use as the b	by Physician/Medi								
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		□Ectopic pregnancy			23d. Date of deli	,
	the att	sici	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4□Pregnant at time of de		Other (specify)			Month	Day Year
P.0	that the death ed by the atte detached for	Phy	9 Unknown Part II. Other significant conditions	t contributing to death but not rec	ulting is the	undoshiga aqueo anyon i	in Part I	23e Did tob	acco use contribute lo	the cause of death?
5	ires tha signed I be del	by	Taren, Other significant conditions	Contributing to death but not rest	annig ar me i	mushying cause given	arrant.	1 □ Ye		bably 4 Unknown
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Records,	has ge 2	Completed						autopsy perform	y prior to d	topsy findings available ompletion of cause of
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	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				w injury occurred	,
Ö	ath. r: Aff	atio	1 Natural 5 Pending 2 Accident investigat	ion	Injury		s 2 □ No			
Division	after de after de I Directo d in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office	28f.	Location (Str. City or Town,	reet and Number or Ru , State)	ral Route Number,
0	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune									
	Hosp 24 hou Fune stely fi	edical	29a. Certifier Certifying (Check only 2 Medical Ex	Physicien: To the best of my know aminer: On the basis of examinat and manner stated.	wledge, dea tion and/or in	th occurred at the time, investigation, in my opini	date and place, and ion, death occurred a	due to the ca it the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	29b. Signature and title of certifier	and marinor states.		29c. License nu	umber	29	9d. Date signed (Month	Day, Year)
	11		0	· · · · · · · · · · · · · · · · · · ·	an 1	D	29025	1	1 2-2	25
	WZ		30. Name and address o person wh			Print) Rando	29035 allstown,	mD	10-1 22	
	_		Allon J. C	hireus no.	5	310 00	a 600,0	- Ro	20 2	21153
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	South ,				
Ų.			APR 4 3	LUUS MANTENES	10-1	-	-			-

			For State Registrar	State of Maryland / Depa	artment of Health and tificate of Death		giene Reg. № 0 0 0 E	122000
	Physici	an	Decedent's Name (First, Middle, Last)	Robert Wil	15 Jr	2. Date of De Month	Day Year	3. Time of Death
	/Medic	Sal	Doyne 4a. Facility Name (If not institution, give sti		4b. City, Town, or Location of Dea	April	28 2005 4c. County of Death	
	Examin	ier	LAUREL REGIONAL		LAUREL		PRINCE G	
	Funeraf		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr. Months Days Hours Mir		th 9. Birth	place (State or Foreign intry)
	Director		218-24-6451 Usual Residence of Decedent	7.4 Yrs.	, ,	FEB. 20		YLAND
	yland 10w		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	e-fsh	ctor	ARYLAND PRINCE (GEORGE'S SILVER	R SPRING_			XXYes 2□ No
	vith th	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
	eath v	Funerai	3160 GRACEFIELD 11. Marital Status	ROAD . Was Decedent Ever in U.S. 13.	20904 Was Decedent of Hispanic Origin?	Specify Yes or No	U.S.	
9	or item	Fun	Never Married 2 Married	V(TYes 2 □ Noppm	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)		
5-0036	72 hours after death with the Maryland natural; or items 23a or 28e-f show iteal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1 ☐ Yes X X No Specify:		Specify: WH	ITE
	n 72 h	Completed	15. Decedent's Educa (Specify only highest grade	ttion 16a. Decer completed) (Give	tent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business/Ir	ndustry
2121	d within piene. r than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)			U.S. NAVY	
	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)			ame (First, Middle,	Maiden Sumame)	
Maryland	Men Men arka	70	DOYNE ROBERT WII			MAE LA		
Ma	and 2 sho alth and 127 is m ar traum		19a. Informant's Name/Relationship (Type MARIA ANNE JOHNS		ng Address <i>(Street and Number or F</i> BLAND DRIVE,			20640
re,			20a. Method of Disposition	20b. Place of Dispo		Date	20c. Location - City or T	
altimore			1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	TIUS CEM. 5-2	-05	BEL ALTON	MARYLAND
Balt	permit. Pag Department importent: i any injury o		21. Signature of Funeral Service Licenses	11004107	Name and Address of Facility CAYMOND FUNERA	I. SERVI	CF. DA	
	25200		23a. Part1. Enter the disease, or complication					Approximate
	Pnysician:		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	504		erosis	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	_ End Stage Ar Due to (or as a consequency of):	ny vi sopnic 14+	trai sa	610315	3 years
	Examiner	_	Sequentially list conditions b. b.	Dysphagia				3 days
V	rted nslt	Examine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (dr as a consequence of):	c respiration	Carlo	9.4	3 1046
oʻ	be executed siclan and burial-transit	Exal	that initiated events c. resulting in death) Last	Due to as a conseque ce of):	c respondition	James	ou.	Jacqs
3760	5 S S	licai	đ.					
9 xo	leath certifica ettending ph for use as th	Physician/Medical	IF FEMALE:	c. If yes, outcome of pregnancy			001 8-1-11	
Bo	death of etten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ory Day Year
P.O.	that the de ted by the e detached	hys	9 Unknown	9□ Unknown				
	res tha	by	Part II. Other significant conditions conti	ibuting to death but not resulting in the u	nderlying cause given in Part I.		obacco use contribute to t Yes 2 No 3 □ Pro	the cause of death? bably 4 □Unknown
Records,	w require been si should t	eted						
Rec	sician: The law certificete has t irector. page 2 s	Completed					prior to co	opsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical		26. Place of De	1 ☐ Yes eath (Check only o	2 1 Yes	2 1 H6
of V		To B	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatier		Home 5 ☐ Resi	dence 6 □Other (Speci	(fy)
o uc	ding Phy h. After thi funeral	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Division	after death. Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str		28f. Location (Street and Number or Run	al Route Number,
D	i Cite	Certification;	4 Homicide	building, etc. (Specify)		City or Tox	wn, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 12 Certifying Physical Cartifying	cien: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as s date and place, and due t	stated, to the cause(s)
.	With To t	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month,	
,			1 0.000	umana MD	D59524		April 29,	2005
1	121		30. Name and address of person who com LOVEEN J. PUTHUMS	HAA, 3110 GRACE	FIELD ROAD, SI	LVERSE	PRING, MD	20904
	Sta		31. Date filed (Month, Day, Year)	32. Abdistrar's Signature	7		····	•
	Registr	ar	MAY 0 9 200	3 Below It for				

	5			For State Registrar		State	of Maryla		artment e <i>rtificate</i>		ealth and M Death	lental Hy	giene	100	5	15634
		D1		1. Decedent's Name (First,	, Middle, Las	st)						2. Date of De	eath Da	v v.	ear	3. Time of Death
		Physici /Medio		Betty Jean	n Wils	son								2005		3:50A [™]
		Examir		4a. Facility Name (If not ins	stitution, give	e street and n	umber)		4b. City, 1	Town, or	Location of Death		4c	County of	Death	
				Upper Chesar						l A				Harf		
		Funeral		5. Social Security Number	6. S	ex □M 2 2 XF		rs. last birthda 70 Yrs.	/) If Under Months	Days Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)		Count	
~		Director		415-52-7369 Usual Residence of Deced			l	78 Yrs.				12/23/	1926) 1	'enne	essee
-,		show			County		10c.	City, Town or	Location						10	d. Inside City Limits
3		Many -f sh	to	MD Ha	arford	}		Aber	deen						i	1. Yes 2 □ No
30		r 28e	Director	10e. Street and Number				12002	10f. Zip	Code			10g. Cit	izen of Wha	at Count	ry?
0		h witi		731 W. Be	l Air	Ave. A	pt. 4B		21	001			Ţ	J.S.A.		
#		deat	Funeral	11. Marital Status		12. Was De Armed F	cedent Ever in	U.S. 13	. Was Deced	ent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No) -	14. Race -	America White, e	
	92	or Ite	F	1 Never Married 2			2 X No		1 Yes 2		Specify:	riioan, oto.)		Specify:		
	5-0036	urel',	d by	3 X Widowed 4 □ Di		Year or	Dates:	1								
5		"nat	lete	(Specify only	ecedent's Ed highest gra	de completed)	(Gi	edent's Usua re kind of wor DO NOT us	k done d	luring most of worki	n <i>g</i>	16b. K	ind of Busin	iess/Indi	ustry
0	2121	12 should be filed within 72 hours after death with the Maryland 3 and Mental Hygiene. 7 ie marked other than "naturel", or iteme 23e or 28e-f show reumetic event, the Madical Examinational Le rolling at	Completed	Elementary/Secondary ((0-12)	College ()	(1-4or 5+)			nema)				Home	2	
-	D	filed Hyg other	Be C	17. Father's Name (First, A	Middle, Last)						18. Mother's Name	(First, Middle	, Maiden			
'n	<u>a</u>		ToB	Ernest L. Sr	mith					İ	Rache	l Reyno	olds			
	Maryland	d 2 should th and Mer 7 ie marke treumetic		19a. Informant's Name/Re	elationship (Type, Print)		19b. Ma	ling Address	(Street a	and Number or Rura	I Route Numb	er, City o	r Town, Sta	te, Zip (Code)
		and and n 27		Gary Wilson		on)					d Point D		erry	ville	, MI	21903
	ore	Pages 1 nent of Hu int: If iter		20a. Method of Disposition 1 Marial 2 ☐ Crem		Removal fron		p. Place of Dis cemetery, cr	oosition (Nam ematory or ot	e of her place	9)	Date	20c. Lo	ocation - Cit	y or Tow	m, State
2	Ë	. Pag tment tent: jury		`4 □Donation 5 □ O	ther (Specifi	y)	Ha	1 1 1			ens 05/0				, MI)
5	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le eny injury or other tre once.		21. Signature of Funeral S	Service Licen	isee 2	- 10-	0.0	Tarrin	Addres 19—Ca	argo Fune:	ral Hom	ne, I	P.A.		
3		TO = 6 0		22a Badi. Estar the disc	200 01 000	elications that					Máryland				_	Approvimate
0				23a. Part1. Enter the diser shock, or heart failure Immediate Cause (Final	e. List only	one cause on	each line.	batti. Do not e	inter the mode)	, such as cardiac o	ii respiratory a	11051,			Approximate Interval Between Onset and Death
		Paysician /Medical		disease or condition resulting in death)	-	a. Ve	Jycu	Mar	ti	bri,	lation				- Te	w Hours
		Examiner				C.	(or as I cons	sequence of):	- 10	· W	acand	in T	mC.	vetio		
5			Jer	Sequentially list conditions if any, leading to immediate	s, te	b. Due to	(o as a cons	sequence of):	CUTC	- 1	yourra	KU T	HE	VCLID	n	
0	V	outed id ansit	Examiner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	1	C	S.								-	
1	60,	an ar		resulting in death) Last	- 1	Due to	(or as a cons	equence of):								
31	876	icate be executed physician and s the burial-transit	dical			d										
	9	eath certific attending pl	Mec	IF FEMALE:		00. 16	. ,									
h	Box	attend for us	lan	23b. Was decedent pregna in the past 12 months			birth 2 F	etal death 3	□Ectopic pre					23d. Date o Month		y Day Year
7	Ö	that the de ed by the a detached	hysician/Me	1 ☐ Yes 2 🗷 No 9 🗍 Unknown		9□ Unk	nant at time o nown	ordeath 5	Other (spe	еспу)						
1	٩.	res that the signed by be detact	0	Part II. Other significant c	ondițions c	ontributing to	death but not i	resulting in the	underlying ca	use give	n in Part I.	23e. Did t	obacco (ise contribu	te to the	cause of death?
-	rds,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	ed by	Khabolomy	10/45	is n	The s	Acute	. Kei	ral	Failure	10	Yes 2	Q No 3[Proba	bly 4 Unknown
(I)	Record	aw recs bee	ompleted	<0.1010	TE	Lon	1.7	10010	~ F	4	on to	24a. Was	an	24b. Wer	e autops	sy findings available pletion of cause of
01		The law ite has b page 2 s	E	Devero	· I	-	h. 4.		1	7	Page lot	autor perio	ormed? 2 \(\text{No}\)	deat	th?	pletion of cause of
.5	Vital	ysicien: The is certificate hadirector, page	Be C	25. Was case referred to n	nedical	e1	PN IV	elvas c	nar		26. Place of Death	W 1				
5	of V		2	1 ☐ Yes 2 ☐ No		Hospital: 1	-inputioni 2	□ ER/Outpati		-	4 Italishing Flor	ne 5⊡Resi	dence	6 □Other (Specify)	
S		Jing Ph n. After th funeral	on:		Pending		of Injury nth, Day Year,	28b. Time Injury		c. Injury Work		28d. Describe	how injur	y occurred		
7	Sio	Vttendii death. ctor: A y the fu	cat	3 Suicide 6	Could not be		a of laium. A	theme form	M		′es 2□No	Of Location /	Ctrant	d Nombor	or Owned	Courte Atimotes
3	Division	after d Direct	Certification:	4 Homicide	determined	buile	ding, etc. (Spe	t home, farm, s ecify)	treet, ractory,	OTTICE	-	City or To	wn, State)	or Hurai	Route Number,
		To the Hospitel or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the fune		29a. Certifier 1 (Check only 2 Me	ertifying Ph	nysician: To the	e best of my	knowledge, de	ith occurred a	t the tim	e, date and place, a	and due to the	cause(s)	and manne	er as sta	ted.
		the H hin 24 the Fi	Medical	One)		and ma	nner stated.	mauun and/or			inion, death occurre	au at the time,				
		To To	4	29b. Signature and title of	n cerumer	1 m	1/)	^	29c.	License	numoer		290. Dat	e signed (N	nonth, D.	ay, rear)
				116	m	111/	/	-m)		Ų	15583		Ma	y 1	70	205
		7		30. Name and address of p	person who	completed car	rse of death (I	tem 23a) (Typ	e, Print)	81	aw str	rect,	· >	beval	ce i	Jankan
		Sta	ite	31. Date filed (Month P	Vegr)	32.	B gistrar's Sig	gnature				2100	+			/ /
		Registi		साम	Y 0 9	2005	Pages o	K	Sand !	7						

DHMH 17 Rev 1/2001

John Notovitch

			For State		State of M	-	partment of H		Mental Hyg	giene	1 27 6 0 50
			Registrar 1. Decedent's Name	(Eirst Middle Las	**1	C	ertificate of L	Jeath	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	_	n Wotov	•				Month V	2 20	ar 100 4
	/Medic Examin		4a. Facility Name (If r				4b. City, Town, or	Location of Death	ППП	4c. County of D	-5
	Exami	Ŭ.	horie	na	River.	side	B	elcam	0	Hart	bro
	Funeral		5. Social Security Nur	mber 6. S		ge (In yrs. last birthd	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	/, Year)	Birthplace (State or Foreign Country)
	Director		179-18-236 Usual Residence of D	6	E-W ZUF	82 Yrs			05/11/1	922 Pe	nnsylvania
	/land			10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man e-f sh iffed	tor	MD	Cecil			Perryville				1 ☐ Yes 2 No
	or 28	Funeral Director	10e. Street and Numb	ber			10f. Zip Code			10g. Citizen of What	t Country?
	ath wi	ral		King Co			2190			U.S.A	·
	itams	nne	11. Marital Status	- 00 Maria	12. Was Decedent	?	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	72 hours after death with the Maryland Instural, or items 23a or 28e-f show dical Exarchet out be indiffed at	by F	1 Never Marrie 3 Widowed 4	_	1 XYes 2 ☐ If Yes, Give Year or Dates:	1941-46	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	2 hou	ted	10	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occupa	ation		16b. Kind of Busine	ess/Industry
215	within 7 ene. than "n	Completed	Elementary/Second	y only highest gra dary (0-12)	College (1-4or	life	ve kind of work done o DO NOT use retired	ouring most of wor)	king		
	filed with Hygiene. Ithar thai		12		00		Machini:				factoring
and	ould be fi Mental H arked otl atic evar	Be	17. Father's Name (F				1			Maiden Sumame)	
Maryland	2 should and Me is mark sumation	2	John Woto	10 00 10 00 10 10 10 10 10 10 10 10 10 1	Type, Print)	19b. M	ailing Address (Street a		Doncak		te. Zin Code)
Ma	nd 2 sulth ar		John F. W				Silver Ki			-	
re,	is 1 au of Hea itam otha		20a. Method of Dispo	osition		20b. Place of Di	position (Name of rematory or other place		Date	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural", or itams 23a or 28e-1 show any injury or other traumatic event, the Madical Examination until be notified at ODGs.		1 ☐ Burial 2 🔀]Removal from State y)	1	rris & Co.	1	4/2005	West Ches	ter, PA
alt	permit. Pag Department Important: any injury c		21. Signature of Fund	eral Service Licer	1588		Tarring Address	igo Fune			
Ш	20129		() Kuic	L C.	Zellm	nan	333 South	Parke ST	., Aberd	een, MD 2	
			shock, or heart	failure. List only	one cause on each	d the death. Do not line.	enter the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician /Medical	2	Immediate Cause (F disease or condition resulting in death)		a	10 cardi	el inta	netray			
	Examiner			- 1	Dute to (or as	s'a consequence of):					
ų	"	Jer	Sequentially list conditions, leading to inno	m einiberi	b. Due to (or a:	s a consequence of).					
V	cuted nd ransit	Examiner	cause. Enter Underli Cause (Disease or in that initiated events	njury	C						
, 0,	icate be executed physician and s the burial-transit		resulting in death) La	ast	Due to (or as	s a consequence of):					
8760,	cate b	dlcal			. d			· · · · · · · · · · · · · · · · · · ·			
9		ധ	IF FEMALE:		23c. If yes, outcome	e of pregnancy				23d. Date of	dolaron
Box	death certif ie attending ad for use as	Physician/M	in the past 12 m 1 Yes 2	nonths?	1 Live birth		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
O.	0 40 5	hysi	9 Unknown	INO	9□ Unknown						
G,	aw requires that the is been signed by th	by P	Part II. Other signific	cant conditions	ontributing to death	but not resulting in th	underlying cause give	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
ord	w require been sig should b	ted	1/2	teiners	deren	ra/ Ku	perfigue's	asin	1□Y	es 2000 3E	Probably 4 Unknown
ecc	e faw r has be je 2 sh	Completed							24a. Was a autop	sv prior	e autopsy findings available to completion of cause of
E H	Th ate pag	Con							perfor 1 ☐ Yes	rmed? deat 200 No 1 □	
Vita	Attanding Physician: Thir death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referre examiner?		Hospital:		Othe		th (Check only or		
of	Phys r this ral di	To To	1 Yes 2		1 L Inpat		tient 3 DOA	4 Prursing H		dence 6 Other (S	Specify)
on	nding Ph th. :: After th e funeral	atlor	1 Natural 2 Accident	5 Pending investigation	28a. Date of Inj (Month, D	ay Year) Inju	y Worl	k? Yes 2 □No		, ,	
Division of Vital Records,	Attandii ar death. ector: A by the fu	tiflea	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place of it	njury - At home, farm	street, factory, office		28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
	rs after sale or sale	Certification:									
	To the Hospital or Attani within 24 hours after dealt To the Funaral Director: completely filled in by the	Medical	29a. Certifier (Check only 2 one)	1 Certifying Ph 2 Medical Exar	nysician: To the bes niner: On the basis and manners	of examination and/o	eath occurred at the time investigation, in my of	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and t	title of certifier	1 1 1		29c. License	e number	- 2	29d. Date signed (M	fonth, Day, Year)
	. 1)			CA	SVW	7 Nun		11975		5/265	
	61		30. Name and addre	ss of person who	completed cause of	death (Item 23a) y	oe, Print)	NAU	nil h	W War	Am Tich
	St	ato	31. Date filed (Mont	h. Day, Y.ear)	a degis:	trar's Signature	H YNDS	1500	47	as your	WITT SILLY
	Regist		"WA	IY 0 9 201	15 Kentur	JA A	ade				,
DH	MH 17 Rev 1/2	001				- 7	-				

			State of Maryland / Per State of Maryland / Per Gr., G844,0	Department of Health at 6/24/05dbb of Death	nd Mental Hygier	15636 long						
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lucy Mabel Walls		2. Date of Death Month April 22,	Day 2005 Year 3. Time of Death 15:00 P M						
	Examin		4a. Facility Name (If not institution, give street and number) Chester River Manor	4b. City, Town, or Location of Chesterton		4c. County of Death Kent						
	Funeral Director		5. Social Security Number 218-20-6220 0	rthday) If Under 1 Year If Under 2 Yrs. Months Days Hours	8. Date of Birth (Month, Day, Yea October11,	9. Birthplace (State or Foreign 1911 MD Country)						
	d within 72 hours after death with the Maryland jene. I then "natural", or Items 23a or 28a-f show It e Madical Exactivational to notified at	rector	10a. State 10b. County 10c. City, Tow MD Queen Anne's Crumpt		10g.	10d. Inside City Limits 1 ☐ Yes 2 ☒ No Citizen of What Country?						
	r death with	Funeral Director	206 Front Street 11. Marital Status	21628 13. Was Decedent of Hispanic Origilif Yes, specify Cuban, Mexican,		USA 14. Race - American Indian, Black, White, etc.						
-0036	thours afte atural; or the	þ		1 ☐ Yes 2 ☐ No Specify:	16b	Specify: Wht						
21215-0036	d within giene. r than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 8 Ma	(Give kind of work done during most of life. DO NOT use retired) ail Carrier	of working Po	ostal Service						
re, Maryland 2 s 1 and 2 should be filed t Health and Mental Hygi item 27 is marked other other traumatic event.			17. Father's Name (First, Middle, Last) Howard Joiner	MAb	s Name (First, Middle, Maid e1 Skaggs							
	ss 1 and 2 shoot the shoot the shoot should be		19a. Informant's Name/Relationship (Type, Print) Catherine Noble/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State P.O. Box 116, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City									
Baltimore,	t. Page rtment o rtant: If njury or		1 XBurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee 22 Name and Address of Facility									
Ä	Dermi Depa Impo		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
8760,	death certificate be executed Wedical e attending physicien and a for use as the burial-transit	lical Examiner		covery transcorp. with Hype	oxia.	Onset and Death						
O. Box 6	at the death certifica by the attending phached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year						
rds, P.	The law requires that the ite has been signed by th bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
al Records,		Completed			24a. Was an autopsy performed							
of Vital	Physician: The this certificate aral director, page	To Be		utpatient 3 DOA Other: 4 Nurs	of Death (Check only one) sing Home 5 Residence 28d. Describe how in							
Division	al or Attending I safter death. I Director: After d in by the funer	Certification;	1	M 1 ☐ Yes 2 ☐ N		and Number or Rural Route Number, ate)						
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death	occurred at the time, date	and place, and due to the cause(s)						
ŧ	with To 1	Σ	29b. Signature and title of certifier O. C. Queulal J. M. L.	29c. License number		Date signed (Month, Day, Year)						
	CA	ate	30. Name and address of person who completed cause death (Item 23a 70 Lin C. Ar. II. H13 A. Th.). 31. Date filed (Month Par Year) 2005 Registrar's Signature	(Type, Print) 4.1 223/Hz4	Street, C/Le	4/27/05 Luntown Wd Z/GZ						
:	. Sta Regist		31. Date filed (Month Pay Year) 2005 Registrar's Signature		·							

			State of Maryland / Department of Health and Me 1 - State Registrar Certificate of Death		iene g. No. 0 0	15 15637
	Physici	an		2. Date of Deat Month		3. Time of Death
	/Medic			April	23 20	Year 2005 10:55 A M
	Examin	er			4c. County o	
			5330 Dorsey Hall Rd. # 213 Ellicott City		Howan	
p.	Funeral		TE Mantha Doug Hause Min	8. Date of Birth (Month, Day Oct. 15	Year)	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	0ct. 15	,1919	OllTO
	ow ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many Inst	to	MD Howard Ellicott City			1 ☐XYes 2 ☐ No
	r 28g	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of W	hat Country?
	th with				USA	
	eme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specific Polyments) If Yes, specify Cuban, Mexican, Puerto Ri	cify Yes or No-		- American Indian,
36	or it			, , , ,	Specify:	
Ö	in 72 hours after death with the Maryland anatural; or iteme 23a or 28a-f show ledical Examinat must be notilled at	d by				WILLE
21215-0036	C * G	Completed	15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	g	16b. Kind of Bus	Iness/Industry
72	illed within I Hygiene. other then "	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 Certified Public Account		Accoun	ting
ğ	be filed withi ital Hygiene. id other then event, it e M	BeC			Maiden Sumame))
Maryland	should be and Mental I marked o	To E	Clarence Raymond Walcutt Mary Power	e11		
lar)	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Informant's Name (Name of Number of Name of			
	and ealth n 27				ey, MD.	
altimore,	90		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)			City or Town, State
Ë	permit. Pag Department Importent: I any injury o				Cheltenh	
Bal	permit. Pag Department importent: i any injury o once.		Guan toway 6512 NW Crain Hwy.	Bowie,		ne 20715
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	est,	Approximate Interval Between
	Pnysician	i n	Immediate Cause (Final disease or condition resulting in death) a			Onset and Death
	/Medical Examiner		Immediate Cause (Final diseases or condition resulting in death) Due to (or as a consequence of): Demodration Demodration Demodration			
		- G	o if any, leading to immediate Due to (or as a consequence 1/2:			
	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ	be executed siclan and burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	ate be	dicai	d			
9	ertifica ling pl e as t	Med	F FEMALE:			
Вох	eath certific attending p for use as (Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date Mont	ol delivery th Day Year
o.	at the de by the a tached	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown			
<u>α</u>	that the ded by detail			23e. Did tob	acco use contrib	bute to the cause of death?
ecords,	The law requires that the death certificate be executed to has been signed by the attending physiclan and page 2 should be detached for use as the burial-transit	ed by		1 ☐ Ye	s 2□No 3	3 Probably 3 Unknown
00	sw requir s been si s should	Completed		24a. Was an	1 24b. W	ere autopsy findings available
Re	The lav ate has page 2	E O		autopsy perform	ed? de	ior to completion of cause of eath? □Yes 2□ No
of Vital R	icien: Th certificate rector, pag	Bec	© 25. Was case referred to medical 26. Place of Death (·	-	Assisted
†	hyeici this cer al direct	70	O 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 🗆 Reside	nce 6 XOther	(Specify) Living
n o	Ter lifer	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Date of Injury 28d. Time of Inj	3d. Describe ho	w injury occurred	d
Sio	Attendin death. ctor; A y the fu	cati	2 Accident investigation M 1 Yes 2 No			
Division	for Attend after death Director;	Certification:	28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	City or Town		r or Rural Route Number,
_	spitel tours nerel filled			nd due to the ca	use(s) and man	ner as stated
	To the Hospitel or A within 24 hours after To the Funerel Direcompletely filled in b	edical	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, da	ite and place, an	id due to the cause(s)
	To To I	Σ	29b. Signature and title of ceptifier 29c. License number	29	od. Date signed	(Month, Day, Year)
,	111		DSU810	h	pro	FJ 7 0005
R	12) Wa		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan Abdo, M.D. 5005 Signal Bell Ln. ((Orksul	le M	10 21029
	Sta Registr		7000 7000			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 7:30 A M ANNE WEINER 04 20 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner BRIGHTON GARDENS** MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F Director 84 Yrs **MARYLAND** 10/20/1920 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23e or 28e-f ehov dref nast be notified at 1 ☐ Yes 2 ☐ No Director MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 TUCKERMAN LANE Completed by Funeral 20852 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ☐ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE 3 ▼ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked of treumetic ever SAMUEL PAPER ၉ SOPHIE COSMAN Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRARA MILLER - DAUGHTER Health a 5700 BALSAM GROVE COURT ROCKVILLE, MD 20852 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of importent: If any injury or once. KING DAVID Donation 5 Other (Specify) 4/22/2005 FALLS CHURCH MEMORIAL GARDENS of Facility 21. Signatur (a) Poperal Service La NATIONAL FUNERAL HOME 7482 LEE HWY FALLS CHURCH, VA 22042 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS SYNDROME resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed that initiated events iding physician and ise as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CONGESTIVE HEART FAILURE, SYSTOLIC DYSFUNCTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? FAILURE TO THRIVE, MALNUTRITION, FRIALITY autopsy performed? COMFORTCARE 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗙 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending 1 XNatural death. investigation 1 Tyes 2 □No 2 Accident Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) COUT 29c. License number Lyan Su D53367 4/21/05

State Registrar

DHMH 17 Rev 1/2001

SHYAMSUNDAR, RAJAN 10810 DARNESTOWN ROAD #202 GAITHERSBURG, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 2 6 2005

			For State Registrer		State of N	naryland	-		of Death			JIENE		15639
	Physicia /Medic		Decedent's Name		_{t)} Mary Fran	ices Wa	arren				2. Date of Dea Month APRIL		2005 ^{Year}	3. Time of Death 10:34 A M
	Examin	-	4a. Facility Name (If I	not institution, give	street and numbe	r)		4b. City, To	wn, or Location	n of Death		4c.	County of Deatl	7
	-		VA MARYLAI	ND HEALTI	HCARE SYS	TEM				RT POI	TI		(CECIL
	Funeral Director		5. Social Security Nui 212-42-1	830	9X 7. A □ M 2 X F	Age (In yrs. Ia 61	st birthday) Yrs.	If Under 1 Months		Min.	8. Date of Birth (Month, Day Sept.19	, Year)	9. Birth Co.	nplace (State or Foreign untry) China
	yland		Usual Residence of D 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	B-fst	to	Maryland	Hari	ford				Havre	de Gr	ace			1⊠Yes 2 No
	th the	ired	10e. Street and Numi	ber				10f. Zip C	ode			10g. Citi	izen of What Co	untry?
	23a	aic	108 Mark	et Street					210	78			U.S.	Α.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Itema 23a or 28a-f show sayl figury or other traumatic event, the Modeal Example multiple and ODGe.	Completed by Funeral Director	11. Marital Status 1 Never Marries 3 Widowed 4		12. Was Deceder Armed Force: 1 [XYes 2 [If Yes, Give Year or Dates	s?] No			nt of Hispanic C Cuban, Mexica &No Specify		cify Yes or No- lican, etc.)		14. Race - Ame Black, White Specify:	
ŏ	2 hou	ted		15. Decedent's Ed	ucation		16a. Dece	dent's Usual	Occupation			16b. K	ind of Business/	Industry
21215-0036	withIn 7, ene. than "n	omple	(Specify Elementary/Secondunknown		de <i>completed)</i> College (1-40 unknow		(Give life.	kind of work DO NOT use Cler	done during mo retired) C	ost of workin	g		unkr	
	Hyg other	Be C	17. Father's Name (F	irst, Middle, Last)					18. Mot	her's Name	(First, Middle,	Maiden	Sumame)	
lan	Mental Mental rked ric ev	To B		Rando	olph un	known				Ċ	Jasmine	Cap	plone	
Maryland	should had and had sume		19a. Informant's Nar	me/Relationship (7	ype, Print)		19b. Maili	ng Address (Street and Num	ber or Rural	Route Numbe	r, City o	or Town, State, Z	Tip Code) 21902
	and 2 salth n 27 i		Aimee Say	lor, Elig	pibility Cl		Action Company	Marie Control				em,	Perry H	Point, MD
Baltimore,	Pages 1		20a. Method of Dispo 1 🖾 Burial 2 □ `4 □ Donation 5	Cremation 3	Removal from Star	e ce	metery, cre	osition (Name matory or oth brest Ce	er place)	04/2	ate 6/05 (gs Mill:	Town, State s, Maryland
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.											P.A.
	Prrysician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	inal	aACUTE		RDIAL	INFAR		as cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death UNKNOWN
68760,	ifficate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list con- if any, leading to immoduse. Enter Underl Cause (Disease or in that initiated events resulting in death) La		c	as a consequ as a consequ								
.O. Box	ne death cer the attendin hed for use	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 m 1 ☐ Yes 2 ☒ 9 ☐ Unknown	⊒Ectopic prec ⊒ Other <i>(spec</i>			23d. Date of delivery Month Day							
α.	uires that the signed by ald be detacted	by	Part II. Other signific HYPERTENS:							t I.			use contribute to	the cause of death?
Records,	e faw has b	Completed	DISEASE, S	SCHIZOPHI	RENIA						24a. Was a autop perfor	sy med?	prior to death?	topsy findings available completion of cause of
Vital	in: The ificete or, pag	e Cc	25. Was case referre	ed to medical					00 DI-	of Dooth	1X Yes		1 🗆 Yes	2€ No
>	Physician: this certific ral director,	0 B	examiner?		Hospital:	ntient 2 V I	ER/Outpatie	nt 3□ DOA	Othor	_	(Check only or		6 □Other (Spec	rific)
on of	fter	tion: T	27. Manner of Death		28a. Date of In (Month, I		28b. Time o Injury		injury at Work?	2	8d. Describe h			
Division of	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of	Injury - At ho etc. (Specify	me, farm, st	reet, factory,			8f. Location (S City or Tow	itreet an n, State	nd Number or Ru	ral Route Number,
	ne Hospi 24 hour e Funera letely filk	Medical (29a. Certifier (Check only one)	1X Certifying Ph 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examinat	wledge, deat ion and/or in	th occurred at nvestigation, in	the time, date a my opinion, de	and place, a eath occurre	nd due to the o	ause(s)) and manner as d place, and due	stated. to the cause(s)
	withir To th	Me	29b. Signatura and t	itle of certifier	0	1		29c.	icense numbe	r	- 4	29d. Da	te signed (Monti	n, Day, Year)
			> /ru	ucia	Jan,	tos	MX	- 4	1094-1			APR:	IL 12, 2	2005
	0		30. Name and addre	SANTOS, I	M.D., VA	MARYLA	AND HE		RE SYST	EM, PI	ERRY PO	INT	, MD	
	Sta Regist		31. Date filed (Mont)		32. Regi	strar's Signa	eru							

			State of Maryland / F	Department of Health and N	•	•
			101	Certificate of Death	Reg.	2005 15710
	9		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medio		ROBERT EUGENE W	HITE	APRIL 1	9, 2005 6:00 P M
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		65 STRAW HAT RD., APT. 1A 5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	OWINGS MILLS thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	BALTIMORE 9. Birthplace (State or Foreign
L	Director		177 M OF E	Yrs. Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Foreign Country) 940 MARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Marylia 1 sho	ro		GS MILLS		1 ☐ Yes 2 M No
	n the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	23a o	aiD	65 STRAW HAT RD., APT 1A	21117		USA
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Never Married 2 ☐ Married 1 ▼ 2 ☐ No 1958 −	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs aft	by F	1 Married 2 Married 1 Mar	1 ☐ Yes 2 ☒ No Specify:		Specify: WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "naturei", or Items 23a or 28a-1 show tha M-Jical Exaction count Le milling at		15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work doze during most of work	168	. Kind of Business/Industry
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d 21		CO	1 2		e (First, Middle, Mai	MILITARY
an	Q 22 D 9	To Be	BOB ERNEST WHITE		RET HOUG	·
Maryland	2 should and Men is marke sumatic	-		Mailing Address (Street and Number or Run		
	rtr		JOSEPH W. WHITE - BROTHER 17	26 WILT RD., NEW	WINDSOR	MD 21776
ore	ges 1 a t of Hea if item or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)		Location - City or Town, State
Baltimore,	permit. Pages I Department of P Importent: If ite any injury or ot		4 Donation 5 Other (Specify) ALL (2. Signature at Service Licensee	COUNTY CREMATION 4	1/20/05	SYKESVILLE, MD.
Ba	Depariment important		1 Source Desirate	22. Name and Address of Facility FLI	ETCHER F	UNERAL HOME
			23a. Part1. Enter the disease, or complications that caused the death. Do r shock of heart failure. List only one cause on each line.	1 254 E, MAIN ST., not enter the mode of dying, such as cardiac	or respiratory arrest,	STER, MD. 21157 Approximate Interval Between
	Physician		Immediate Cause /Final	INFARCTION		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence			
н	LAdilillei	2	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)			
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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3760,	2 2 2	cai	CEREBRA VAS	SCULAR DISEASE		
x 68	The law requires that the death centificate to the laws been signed by the attending physic age 2 should be detached for use as the board.	Physician/Med	IF FEMALE:			
Вох	attend for us	cian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
O.	that the de led by the a detached f	nysid	1 Yes 2 No 9 Unknown 9 Unknown	5 Li Ottlor (specify)		
ο,	es that igned to be deta	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	w require been sig should t	eted	STROKE		1 ☐ Yes	2 X No 3 ☐ Probably 4 ☐ Unknown
ecc	e lawr has be je 2 sh	npie			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al H		Comple			performed 1 ☐ Yes 2 🔀	!? death? No 1 □ Yes 2 □ No
Vital	Phyaician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Other	Check on one	e 6 □Other (Specify)
of		 	27. Manner of Death 28a. Date of Injury 28b. 1	ime of 28c. Injury at	28d. Describe how i	
sior	Attending r death. ector: After by the funer	atio	2 Accident investigation	njury Work? M 1 Tyes 2 No		
Division	al or Attend after death i Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specily)	rm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospitel or Atte within 24 hours after de To the Funerei Directo completely filled in by th	Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge	death coourad at the time, data and place	and due to the same	2(2) and managed at the
	e Hos 124 h e Fur letely	edical	(Check only 2 Medical Examiner: On the basis of examination an one)	d/or investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	WSL		(Clariti Ken. 1	D0027075	4	/20/05
	2		30. Name and a briss of person who completed cause of death (Item 23a)		MD 01	126
	Sta	te	CLAUDIO LEVIN, MD 750 MAIN 3 31. Date filed (Month, Day, Year) 32. Regionar's Signature		, мр. 21	136
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United Residence of Decisions 100 County										Min.	8. Date of Birth (Month, Day,	Year)	9. Birtl	nplace (State or Foreign untry)
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Provided Cause (Final dease) of reaching conditions are served in death) Sequentially is conditions are served in death) Sequentially is conditions.	<u> </u>	88888		1-6MESCO	as smi	20	43	J GOV. K	TICIT	е пму	, sever	па Р	ark, M	D 21146
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Tayle (agading to immediate agades) Commediate agades Commed		/Medical	1	diseas r condition resulting in death)	a. Due to (or	as a conseq	uence of):	CK						
The state of the s	В	Examiner		Sequentially list conditions,	b. E. C	زان	Back	revemi	a					
The state of the s		ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence of):						- 4	
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	oʻ	an and rial-tra	Exal	that initiated events	c. Due to (or	as a conseq	uence of):							
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	876	ate be hysicia the bu			d	_								
9 Unknown 9	9	certific Iding p	/Med		23c. If yes, outcor	me of pregna	ancy					23/	d. Date of doll	ivan,
The state of death of the state of death of		death e atter	iciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant	t at time of d			у			200		
24a. Was an autopsy performed to cause of death? 24a. Was an autopsy performed to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 28. Death 28. D	P.0	at the d by th letachs	Phys				Minn in Alan		in Book i		220 Did to			the server of death?
25. Was case referred to medical examiner? 1	ds,	uires ti signe Id be c	d by	and the contract of the contra			_	riderlying cause gr	A GET IN THE OFFICE	•				
25. Was case referred to medical examiner? 1	COL	aw req s beer 2 shou	piete	Acute Re	nal Fail	lurc							24b. Were au	topsy findings available
25. Was case referred to medical examiner? 1 Yes 2 Mo 1 Yes 2 Mo 26. Place of Death (Check only one) 1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Describe how injury occurred 28b. Describe how injury occurre	- Re	The ate ha	Com								perform	ned?	prior to death?	2/2/No
The state of the s	Vita	iclan: certific ector,	Be	examiner?	Hospital:	/		0*	200					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD YOUNG MD Annedrumbel Medical Carlo Annapolis MD 21461	of	g Phys er this eral di		27. Manner of Death	1 minpa		28b. Time o	f 28c. Inju	ry at					cify)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD YOUNG MD Annedrumbel Medical Carlo Annapolis MD 21461		the Ho nin 24 the Fu		one)	and manner	s of examina stated.	ition and/or in			ith occurre				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD YOUNG MD Annedrumbel Medical Carlo Annapolis MD 21461		To To	-	290. Signoture and tille of certifier	5					97	2	ed. Date :	signed (Monti	n, Day, Year)
HOWARD YOUNG MD Annetrudel Medial Carlo Annapolis MD 21401		(-	30. Name and address of person v	who completed cause of	of death (Iter	n 23a) (Type,	Print)				V	11(0))
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature				11	SC MD	Ar	ine-tro	moel 1	مرکزد	20	ale	Ann	apolis	MD 21401
Registrar MIN W 2003		. Sta Regist		APR 2 2	2005 32 Regi	istrar's Signa	ature	mark!						

		ľ	For State of Maryla		artment of H ctificate of L			iene20)5	15642
			Decedent's Name (First, Middle, Last)				2. Date of Deat			3. Time of Death
	Physicia		William White JR.				April		Yeer 005	0830 M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	th	4c. County of	f Deeth	
	LAGITITI	٠.	816 Miami Avenue		Sali	sbury		Wico	omic	0
	Funeral		5. Social Security Number 6. Sex 7. Age (In ye	s. last birthday)	If Under 1 Year Months Days		8. Date of Birth	Year)	9. Birthpl	ace (State or Foreign
	Director		214-34-8354 ¹\XM 2□F 68	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Feb. 16	1937		"land
	D		Usual Residence of Decedent							
	show		10a. State 10b. County 10c.	City, Town or Lo					110	0d. Inside City Limits 1 Yes 2 No
	Ba-f s	5	Maryland Wicomico	Sa	lisbury					
	or 20	Director	10e. Street and Number		10f. Zip Code		11	0g. Citizen of W	hat Coun	try?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	ra .	816 Miami Avenue		2180			U.S.F	~	
	tame tame	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (5 n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	- America , White, e	
5	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Married 1 ☐ Yes 3 Married		1 ☐ Yes 2 🔀 No	Specify:		Specify:	D1 -	-1-
0000	within 72 hours after ene. then "netural", or Ite for Wedical Examine	b b	3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus	Bla	
ņ	n 72	ete	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired.	turing most of wo	orking	TOD. INITIO OF BUS	1110321110	ustry
-61717	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Lab	orer			None		
_	filed Hygi other ant,		17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, A)	
/iand	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 them 23s or 28s-1 show Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic avent, the Mcdical Expendent must be notified at	To Be	William White Sr.			Hatt	ie Gosle	ee		
	2 should be and Mental is marked aumatic av	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a		ural Route Number,		State, Zip	Code)
Ma	ath a	1	Donald Corbin (Stepson)	7479	Fentral	Ave.S	alisbury	,Md.21	801	
<u>a</u>	Health tem 27 other tr	1		. Place of Dispo		!	Date	20c. Location - 0		wn, State
2	Pages nent of int: If It iry or o		1 ₩ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	•	.11 Mem.		4/29/05	Hebror	h Md	
animore,	그 문원 중		21. Signature of Funeral Service Licensee		Name and Address		4.		1,110	•
ñ	Departing Department of the police.		Gladys B. Stewart				ı ноше lisbury,	Md 218	301	
	*		23a. Part1. Enter the disease, or complications that caused the dishock, or heart ailure. List only one cause on each line.							Approximate
			shock, or hearthallure. List only one cause on each line. Immediate Cause (Final	ish he	. Prostal	۵) م				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a cons		01021001	-			-	
	Examiner		Dub to (5) as a cons	equorico or).						
4	1000	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Under in.	equence of):						
	uted d ansit	늘	cause. Enter Under in Cause (Disease or injury that initiated events							
<u>_</u>	exec in an	Examiner	resulting in death) Last Due to (or as a cons	equence of):						
8/60	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	cal	d							
2	tificat g phy as th	Physician/Medical		-						
X Q Q	leath certifi attending I for use as	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre- 1 □ Live birth 2 □ F		Ectopic pregnancy			23d. Date		•
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Mon	th	Day Year
J.	at the de by the a	hys	9 □Unknown							
	res tha igned l	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	_	bute to th	e cause of death?
ğ	v require been sig should t						1 □ Y€	s 2 No	3 Proba	ably 4 □Unknown
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ř	9 7 9	E					perform	ned? de	eath?	
Vital	sician: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of De	ath Check only on			
	S S	To B	examiner? 1	□ ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing	Home 5 Heside	nce 6 Othe	r (Specify)
0	ig Ph		27. Manner of Death 1. Whatural 5. Dending (Month, Day Year	28b. Time o	f 28c. Injun	at	28d. Describe ho	w injury occurre	d	
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Division	r Atte	tifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe		reet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rura	Route Number,
ā	rs aft at Di	Certification:								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	edical	29a. Certifier 1 Certifying hysician: To the best of my (Check only 2) Medical Examiner: On the basis of exam	knowledge, deat	h occurred at the tim	ne, date and place	e, and due to the ca	ause(s) and mar	ner as st	ated. the cause(s)
	the F the F the F	fedi	and manner stated.							
	To To Con	Σ	29b. Signatule and title of certifier		29c. License	NUC)	2	9d. Date signed ししょして	(Month, L	Jay, rear)
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	No	. "	30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print) (vo (1 St.	Sali	Shun 1	MO 2	180	
	Sta	te	31. Date filed (Month, Day, Year) 32. Projectar's Si	gnature	4	<u> </u>	1)			
	Regist		APR 2 6 2005	H A	berli					

ysici		1. Decedent's Name (First, Middle, L	. *					ith and i	2. Date of De Month		y, Year	3. Time of	Death
Medic		VIRGIN	(A		N	ILKEN			2	34	1 05	7:36	P
amin		4a. Facility Name (If not institution, g			,	4b. City, To		ation of Death	1		. County of Dea		
		PRINCE GEORGE'S 5. Social Security Number 6.		ENTER 10 (In yrs. las		If Under 1	CHEVE	ERLY Inder 24 Hrs.	9 Date of Ris	1		HEORGE!	
eral ctor		577-86-4328	1□M 2XF	59	Yrs.			ours Min.	8. Date of Bir (Month, Da	y, Year)	Mar	rthplace (State of Country) 'Yland	ir r-orei
		Usual Residence of Decedent											
H	_	10a. State 10b. County			Town or Lo							10d. Inside C 1 X Yes	•
Sillis	Director	DC 10e. Street and Number		Wash	ningto	n 10f. Zip C				40- 0'			
1	급	4424 20th Stree	t. N.W.			TOI. ZIP C	2001	R		US.	tizen of What C	ountry?	
other traumatic event, the Medical Exempler traut be nulliked at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Deceder			pecify Yes or No o Rican, etc.)		14. Race - Am		
Till I	Ξ	1 X Never Married 2 ☐ Married	Armed Forces? 1 Tes 2 X			tYes, specify 1 □ Yes 2 0	_	exican, Puert oecify:	o Hican, etc.)		Black, Wh		
Eva	d by	3 Widowed 4 Divorced	Year or Dates:									hite	
edice	Completed	15. Decedent's (Specify only highest g	Education rade completed)			dent's Usual (kind of work DO NOT use		g most of wor nknown	king	16b. K	ind of Busines	s/Industry Un	kno
the M	dwo	Elementary/Secondary (0-12) Unk	College (1-4or	5+)		30 110 / 330	Ui	nknown					
ant.	Be C	17. Father's Name (First, Middle, Las	st)				18.	Mother's Nar	ne (First, Middle	Maiden	Sumame)		
tic e	To B	Burnell Wilkins					Ga	arnet	E. Unl				
raumatic evant, the Med		19a. Informant's Name/Relationship							ral Route Numb				
any injury or othar tra		Willie Byrd/ Cas	e Manager	20h Bio		sition (Name		. w . , w	ashingto Date				
or ot		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation 3		cer	netery, crer	natory or oth	r place)	001			ocation - City o		
njury	1	4 □ Donation 5 □ Other (Spec21. Signature of Funeral Service Lice		Rive		Park Name and		. 03/	11/05	Rive	erdale,	Márylan	d
any i		Wanda C. Ba		CC361					10H8me,	Inc	., 3447	14th S	t.l
		23a. Part1. Enter the disease, or co	mplications that cause	d the death.								Approximat	e
cian		shock, or heart failure. List on Immediate Cause (Final	INTRACE	RERRI	Li -	HEMM	ORHA	GE				Interval Bet Onset and	
dical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	71011101			1 / 1	,		1	
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9	Aedicai	NE COLLIE	d										
se as the	an/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome 1 □ Live birth	of pregnand		Ectopic preg	nancy				23d. Date of de		Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5644 Registramend item #7 per fh g843 5/1990 item #7 per fh g843 5/1990 item #7 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BARBARA 0652 AM ATWELL 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT 28, 19 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) D1St11Ct 10 M Months Days Hours Yrs. Director 216-28-3567 1931 of Columbia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or then "natural", or itams 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3000 N. Ridge Road 21043 USA Compieted by Funerai 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic .. Pages 1 and 2 should be filed vitment of Health and Mental Hygle tant: If Item 27 is marked other talury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard N. Atwell Ethel Layton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433 Manor Lane Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) Miriam A. Mathews/sister permit. Pages 1 and Department of Healti Important: If Item 27 any injury or other 1 <u>once.</u> Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 5/9/05 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun trai Service Licens Cremation Society of Maryland, Inc. McDonald Dawn F. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CU DISEASE Physician ATHEROSCI EROTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ned by the atte in the past 12 months?
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9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 1 ☐ Yes 2 ☐ No Completed HIZOPBRENIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Aftar 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funaral Direct completely filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50303 Fernovde ed cause of death (Item 23a) Print) Catonsville, MD Rd ste 162

Registrar DHMH 17 Rev 1/2001

State

. Registrar's Signature

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MAY 1 0 2005

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6, CLEMENTINE ABBOTT May 2005 11:28 A.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holly Hill Manor Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 95 Director 215-03-5343 Yrs. 1910 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 531 Stevenson Lane 21286 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive 10 years Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental | ant: If item 27 Is marked o Harry Clarke Abbott Anna Christina Dennisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Five Farms Lane Timonium, Maryland 21093 Doris Walker (niece) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If eny injury or once. 5-11-05 | Baltimore, Maryland Moreland Memorial Park ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee ren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician omontia disease or condition resulting in death) /Medical to (or as a consequence of) Examiner theroscleratic cardiovascular disease Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by pe (1 Yes 2 No 3 Probably 4 inknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed res 2 1 Yes 2 No 1 ☐ Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-17041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leavey LABB Lutherville MD 1205 York Ro , CM, 31. Date filed (Month, Day, Year) Registrar

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () () 5 5646 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year SADYE MAY **AARONS** 4:45 P ^M 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOLLY HILL MANOR TOWSON BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year, 11/12/1908) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 20XF Days Months 215-22-6775 96 CT Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 531 STEVENSON LANE 21286 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛮 No WHITE If Yes, Give Year or Dates: Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WEINBERG DAVID BELLA STILLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 OLD FOREST ROAD, BALTIMORE, MD 21208 RICHARD AARONS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10 Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH HILLEL MEMORIAL 05/11/2005 EAST GRANBY, CT. * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ZAMON 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebrovascular 1 days disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform rmed? 2 🔊 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No

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permit. Pege Department of Important: If any injury or once.

other traumatic evant. The Medical Examiner must be notified at

Be Completed by Funeral Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner use as the burial-transit Physician/Medicai ŏ should be detached Completed by page 2 director, After thi within 24 hours after death To tha Funaral Diractor: / completely filled in by the f

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Certification; To Be Medical

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

1 X Natural 2 Accident 5 Pending investigation М 6 Could not be determined 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier Gendelsman

Lutherville

29d. Date signed (Month, Day, Year)

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surte

31. Date filed (Month, Day, Year) MAY 1 0 2005 32 Registrar's Signature



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21	e filed within al Hygiene. other then vent, the we	mo:	12 + HGRADE	MAG	CHINE	OPERA	TOR	BAK	ERY
	othe othe	Bec	17. Father's Name (First, Middle, Last)				(First, Middle, Ma		
Maryland	should be ad Menta marked matic ev	To E	WILLIAM A. BLAKE	\subseteq		FLORE	NCE	Sc.	OTT
an	2 sho and 1 ie me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin				ity or Town, State, Z	' '
Σ	127 F		FLORENCE BANKS (MOTHER)	290	22 CAR	VER RE	AD BA	LTO, MD	. 21235 Town, State
ore.	ges 1 au it of Hea if item or othe		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State	e of Dispos	ition (Name of atory or other place)		ate 200	c. Location - City or	Town, State
Baltimore	Pages nent of ant: if it ury or o		'4 □ Donation 5 □ Other (Specify)	NITH	CEMETE	RU15-1	3-05 /	BAITIMA	RE MA
alt	permit. Page Department Importent: any injury once.		21. Signature of Funeral Septice Licensee	- 2	Name and Address	of acility 3	20411/17	R. FUNEA	RE, MD. RAL HOME 10.21217
Ω	Per De per per per per per per per per per pe		XXXXXXXXX	3	2/40 N.	FULTO	NAVE , A	BALTO, M	10.21217
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or lear failure. List only one cause on each line.	Do not ente	r the mode of dying,	such as cardiac o	r respiratory arrest		Approximate Interval Between
ш	Physician		Immediate Cause (Final disease or condition						Onset and Death
1	/Medical	8	resulting in death) a. Due to (or as a consequent	nce of):					2 01173
М	Examiner		Sequentially list conditions, b. JEJUNO - I	LIES	ITIS AND	PERITO	NITIS		7 DAYS
	₽ ≒	Examiner	if any, leading to immediate Due to (or as a consequen	/-			0.7		10.2/51.56
	nd trans	am	that initiated events		UNE DEF	ICIENC	JYNDE	POME	10 YEARS
Ö,	ian a		resulting in death) Last Due to (or as a consequent	nce of):					
8760,	cate be executed physician and the burial-transit	dicai	d						
9	leath certific attending p		IF FEMALE:						
Вох	death certifi e attending I ad for use as	ian/	23b. Was decedent pregnant in the past 12 months?	eath 3 🗌	Ectopic pregnancy			23d. Date of deli	very Day Year
0	0 0 0	Physician/Me	1 ☐ Yes 2☐No 4☐ Pregnant at time of death 9 ☐ Unknown 9☐ Unknown	h 5□	Other (specify)			William	Duy 76a.
٩.	that the de ed by the detached	Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the un	dorhina cauco awon	in Cort I	23a Did tobac	co use contribute to	the source of death?
ds,	ng be	Completed by	HEPATITIS C	ng ar are arr	derlying cause given	iii raiti.	1 Tes		Y
0	w requir	etec		Be-			-	2010 00710	John Town
3ec	e law has t	npl	END STAGE RENAL DISEASE				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
=	10	Col					performed 1 ☐ Yes 2	d? death? No 1 ☐ Yes	2 No
V Etc	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Death			
ot	Physician: this certific ral director,	To		VOutpatient	-	4 🗀 I faul 3 ling 1301		e 6 □Other (Spec	ify)
u C	Jing After fune	ion	1 □Natural 5 □ Pending (Month, Day Year)	Bb. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	ns 2 □ No	8d. Describe how	injury occurred	
S	I or Attending after death. Director: Attel I in by the fune	ica	2 Accident investigation 3 Suicide Could not be determined 28e. Place of Injury - At home	a farm etro			Rf Location (Stree	t and Number or Ru	ral Bouto Number
Division of Vital Records,	after Dire	Certification:	4 Homicide determined 288. Place of Injury - At nome building, etc. (Specify)	5, 141111, 3110	et, ractory, office		City or Town, S	itate)	ar noute Number,
_	spite ours nerel filled		29a. Certifier Certifying Physician: To the best of my knowle	dge, death	occurred at the time	date and place a	nd due to the caus	a/s) and mannar as	tated
	To the Hospitei or At within 24 hours after or To the Funerel Direct completely filled in by	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my opin	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
	Fo th Within Fo th sompl	E e	29b. Signature and title of certifier		29c. License n	number	29d.	Date signed (Month	, Day, Year)
	1		MD MD		000	RES	M	44-07-	05
/	R		30. Name and address of person who completed cause of death (Item 23	3a) (Type, F					
1	U`		MANJWATH MARKANDAYA	300	15. HAN	LOVER ST.	REET BA	RAMORE	= MD, 21225
	5 Sta	ite		8	٠. فد		1100		1 -101003
	Registr	ar	WAY 1 0 2005 Brans &	for	West !				

		1	For State Registrar	State of Maryla		rtment of H			ene 005	15648
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last A A C A C A C A C A C A C A C A C A C	NOA BRO	w.J	4b. City, Town, or		2. Date of Death Month		3. Time of Death 5- 11 42-A M
	Examin Funeral Director	er	5. Social Security Number 6. Se	erick Ro	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	BALT	1 MO KE thplace (State or Foreign ountry) MD
	he Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County BALTIMO		City, Town or Lo	ILLE				10d. Inside City Limits 1 ☐ Yes 2 1 No
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "neturel", or flems 23e or 28e-f show event, the Medical Examinational the notified at	Funeral Dir	10e. Street and Number 6332 FREDRICK 11. Marital Status	12. Was Decedent Ever in Armed Forces?		10f. Zip Code 2122 Vas Decedent of His i Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	og. Citizen of What Co USA 14. Race - Ame Black, Whi	erican Indian,
21215-0036	n 72 hours aft "neturel", or enical Exemi	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 图 Divorced 15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occupa kind of work done do OO NOT use retired,	luring most of work	ing 1	Specify: BL	ACK /Industry
and 212	be filed tal Hygid d other event, I	Be	Elementary/Secondary (0-12) 12 TH GRADE 17. Father's Name (First, Middle, Last) FRANK JALLEY	College (1-4or 5+)		CARE PR	OVIDER	e (First, Middle, M BOONE		RE
e, Maryland	1 and 2 she Health and hm 27 is m ther treum	2	19a. Informant's Name/Relationship (7) EMERSON JOHN 20a. Method of Disposition	180N (30N		g Address (Street a	nd Number or Rur	al Route Number,	City or Town, State,	ID 21228
Baltimore,	permit. Pages Department of I Importent: If ite any Injury or or once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	cemetery, cren ING PAR	natory or other place Name and Addres WHN C. G	05.16	2.05 F JERAL SEA	RANDALLSTO EVICE	CM, NW
	Physician /Medical		23a. Part1. Enter the lisease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a UNA	eath. Do not ente				MO 21229	Approximate Interval Between Onset and Death
0,	Examiner and I-transit	Examiner		Due to (or as a cons	sequence of j.					/
.O. Box 68760,	death certif e attending d for use as	Physician/Medical	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3 [Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, P.	requires the een signed nould be de	by	Part II. Dther significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause give	n in Part I.		acco use contribute to	o the cause of death? robably 4 □Unknown
Vital Rec	The larate has	Be Completed	25. Was core referred to medical examiner?				26. Place of Deat	24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
of	y y	၉	1 Yes 2 No 27. Many or of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	at	me 5 Mesider 28d. Describe how	nce 6 Other (Spe w injury occurred	icify)
Division	o the Hospital or Attending Phithin 24 hours after death. o the Funerel Director: After thompletely filled in by the funeral	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Special Control of the best of my	ecity) knowledge, death	accurred at the tim	e date and place	City or Town,	use(s) and manner a	s stated
	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier	ner: On the basis of exam and manner stated.	nination and/or inv	29c. License	inion, death occur	red at the time, da	te and place, and due	to the cause(s)
1	0.4		30. Name and address of person who co	1 Sor - 34	143 55	Print	LACER	201, 6	MAGS, T	11005 11005
8	Sta Registr	.46	31. Date filod (Month, Day, Year) MAY 1 0 200	5. Registrar's Si	gne ure	de)		7		21062

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Jennie 4:00 M MAY MAE 2009 /Medical 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death RAVEWOOD BALTIMORE NURSING HOME NIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, D4, 28. 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 K F 214.12.4233 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. County d other then "naturel", or Items 23a or 28e-f show event, the Medical Erapiner must be notified at 10d. Inside City Limits N BALTIMORE 1 X Yes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 STREET W. 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11/14 GRADE HOME MAKER DOMESTIC NA marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM PARRISH ANNIE CHARITY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Department of Health ar Importent: If item 27 le any injury or other trau 2009. 13030 TRIADELPHIA RD., ELLICOT CITY, MD GREENE BARBARA BUILER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS 05 ·II- 05 BALTO. MD 21. Signature of Funeral Prvice Licensee

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATC PIKE BALTO. MD 2122

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final Physician THEROSCUERONE CARDIOVASCULAR DUEASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ate has bage 2 s autopsy performed' 1 Yes 2 E NO 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check on one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Cther: 4 | Horsing Home 5 | Residence 6 | Other (Specify) di. 2 2 40 1 Tyes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: I Director: After I d in by the funera 28d. Describe how injury occurred 1 ☐Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel within 24 hours a To the Funerel & 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

N. FUNTAWST.

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CUMAN 821

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MVASANTUA

MAY 1 0 2005

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Year **Physician** 3:00 p.m. W. Brown, Sr 5 2005 Walter /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Longgreen Genesis Health Care Balto If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Hours **Funeral** Yrs 249-38-7567 Director 78 7-28-1926 S.C. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. Stete 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryler Depertment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be norithed at 1X Yes 2 □ No Md N/ABalto Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 33rd Street 1040 E. 21218 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Westinghouse 12th grade N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Lest) Be Ernest Brown Minnie Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Verna Lee Brown -Wife 1040 E. 33rd Street Balto, Md 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-11-05 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet March F/H West 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Wabash Avenue Balto, Md 21215 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RENAL Examiner Due to (or as a consequence of): Examiner heart totial or Attending Physician: The law requires that the death certificate be executed ours after death.

weral Director: After this certificate has been signed by the ettending physician end "filled in by the furnered director, page 2 should be deteched for use as the buriet-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, ypertusion by Physician/Medicai Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CAUCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pothyroidism 1 Yes 2 No Anenic 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie edicai (Check only one) and menner stated. 29d. Date signed (Month, Dey, Yeer) 29c. License number 295. Signature and title of certifier D0059056 D Squic MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Salvic 31. Dete filed (Month, Day, Year) WEST 1600 2. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

0 2005

05-03023 Charles Barnes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici		1. Decedent's Name (First, Middle, La							2. Date of D Month		Y	3. Time of	Death	
/Medic		Charles	Barne	s						April	38 ^{ay}	200	5 13:1	5
Examir	er	4a. Facility Name (If not institution, give Prince George's H		nton		,		Location o	f Death			ounty of I		_
				e (In yrs. lasi	t hirthday)	If Under		rerly	24 Hrs	9 Date of B			George's	
Funeral Director			MgM 2□F	21	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D June 2	4, Year) 4, 19		Country) ashington	
		Usual Residence of Decedent		40- 0:	C									
shov M	ក	10a. State 10b. County	1. •	10c. City, T									10d. Inside City Limits 1 🛣 Yes 2 □ No	
28e-f	Director	District of Columbia Washington 10e. Street and Number 10f. Zip Code 921 Tofferston Street N. F. 2							10g. Citizen of What Country?					
38 or	I Di	921 Jefferston Street N.E. 2001.							.1		Unite			
Department of Health and Mental Hygiene. Important: or Items 23e or 28e-f show Important: If item 27 is marked other then "naturat", or Items 23e or 28e-f show any injury or other treumatic evant, If a Medical Evandrer must be notified at 2008.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Never Married 2 ☐ Married 11. ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, F If Yes, specify Cuban, Mexican, F If Yes, specify Cuban, Mexican, F If Yes, specify: 11. ☐ Yes 3 ☐ Yes Specify:								in? (Specify Yes or No-Puerto Rican, etc.)			Race - American Indian,	
or le	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Yes No Specify:			, ,	can, etc.) Black, Wi		Black					
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giene er the	Com	Ninth	Const	onstruction Worker					Pr	ivate	e			
d oth	Be	17. Father's Name (First, Middle, Last Archie Mack Port		18. Mother's Name (First						e, Maiden S	umame)			
d Men narke natic	^L	19a. Informant's Name/Relationship		Print) 19b. Mai			(Street o			ral Route Number, Cit		Tour Cto	ato Zie Code)	
th and		Archie Mack Porte				-							C 20011	
Heal item		20a. Method of Disposition		20b, Plac	e of Dispo	sition (Nam	e of			Date			y or Town, State	
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Departm Importa any inju pnce.		21. Signature of Funeral Semice Lice	nsee		22	. Name and	d Addres						eral Home	
. A E & 8		Ppyl. L	W.111	/									20020	
Medical and physician and rose as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate that the start of the st	nce of):	d to head										
by the attending lached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of pregnancy 2 Fetal de time of deat	Fetal death 3 □Ectopic pregnancy					23d. Date of del Month				/ear	
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en sig	ompieted								24a. Was an autopsy 24b.			prio deat	re autopsy findings r to completion of city?	
ate has b page 2 s	ä o O									(Check only				
ate has page 2	Be	N IN Inpatient 2 ER/Outpatient 3 DOA											(Specify)	
rthis certificate has ral director, page 2	To Be	1X Yes 2 No 27. Manner of Death	5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						28c. Injury at Work? 28d. Describe how injury occurred					
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leath. tor; After this certificate has the funeral director, page 2	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to	28a. Date of Injunction (Month, Day) on 1071 23 2 28e. Place of Injunction	Year) 2005 ury - At home	0:40			/es 2)X 0,1		28f. Location	(Street and		or Rural Route Num	ber,
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State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
spitel or Attending Physicien: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death with the
outs after beam. Insert Discotor: After this certificate has been signed by the attending physician and point in the funeral director pane 2 should be detached for use as the burial-transit process.	Department of neathrand memary hyperie. Important: If frem 27 is marked other then "naturel", or Items 23e or 28s any injury or other treumetic event. Its Medical Examine must be not
er	опся.

G		•	For State Registrar	otate of Maryland	-	rtificate of			Reg. No.	05	15652
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of De		Year	3. Time of Death
	/Medic	al	TRUMAN GEORGE		_	. O. T	1 - 1 - 1 D - 1 h	May 3,			9:21 А м
	Examin	<u>.</u>	4a. Facility Name (If not institution, giv 245 C Street Dock	КН		Solomon			Calv	nty of Death 7ert	
	Funeral Director		403-34-9000	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 02/13	y, Year) 1937	9. Birthp Coun TEXA	place (State or Foreign htry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh	tor	MD CALVE	RT	SOLO	MONS					1 ☐ Yes 2 No
	ith the	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	itry?
	eath w	eral	P.O. BOX 982	12. Was Decedent Ever in U.S.	12	20688		opifu Vos ar No	USA	Race - Americ	ean Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumetic event. The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cubi	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
20	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usual Occup	pation during most of work d)	ing		f Business/Inc	dustry
121	within ane. then "	Completed	Elementary/Secondary (0-12) 12YRS	College (1-4or 5+)			ogrammei		COMP	RAMMI	NG
9	filed Hygie other ent,	e Co	17. Father's Name (First, Middle, Last,		00111	OIDK IK	18. Mother's Nam				
<u>Ian</u>	uld be 1 Mental I irked or itic eve	To Be	TRUMAN G. BROV	NN SR.			MARY K	ATE AR	D		
Maryland 21215-0036	2 sho and h Is ma		19a. Informant's Name/Relationship (**							Code) 22201
e,	1 and Health em 27 ther t		JENNIFER BROWN 20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of	DOLPH S'	I'. APT		ARLI on - City or To	
JOIL L	ages ant of it: If It		1 ☐ Burial 2 ★ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)	Removal from State	netery, crei	matory or other place		15/06/		•	CITY, MD
altimore,	permit. F Departme Importar any injur		21. Signature of Funeral Service Licer		22	2. Name and Addre	ss of Facility				
<u>m</u>	20 = 3	- 13	Williad of	Well			JENKIN: RK RD M			21111	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not en	er the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	0.0	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Hypertensive a	200 00: 1	BUTEVUILLE	L. I. h. D	50 13 0 114	1) loca	ese	
	Examiner				iles oi).	oruplica	tha by 10	Y OLOFI IN	9		
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):						
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	nce of):						
68760,	a be e) sician buria		l	A.							
9	rtificate be executed ng physician and s as the burial-transit	Medical									
Вох			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	eath 3[Ectopic pregnancy	y		1	Date of delive Month	ory Day Year
P.O.	that the death ce ed by the attend detached for us	Physician/	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown	th 5[Other (specify) _					
	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	by Ph	Part II. Other significant conditions	contributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
Division of Vital Records,	w requires that s been signed t should be det	led b						1 🗆 1	∕es 2,20 No	3 Prob	ably 4 Unknown
eco	e law re has be ge 2 sh	Completed						24a. Was autop	sy	prior to cor	psy findings available mpletion of cause of
a H	r: The							1 Yes	rmed? 2 No	death? 1 XYes	2 No
Ĭ	s certif	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outnatier	nt 3 DOA Oth	26. Place of Deat			ther (Specifi	d at toon
3 Of	ig Phy ter this neral c		27. Manner of Death	28a. Date of Injury 2	8b. Time o			28d. Describe h			at scen
Sior	endin eath. or: Af	catlo	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n Founds 3 05	gund	A M 10	Yes 2 No	Salo		sowne	
Š	lor Att after d Direct	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or Tov	vn, State)	imber or Rura 45 C S	I Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	nysician: To the best of my known miner: On the basis of examination	edge, deat	havbor	me, date and place,	and due to the	cause(s) and	manner as st	ated.
	the H hin 24 the F	Medical	one)	and manner stated.		29c. Licens					
}	To To I		29b. Signature and title of certifier	Hallan w	\$	OCM			1ay 4,	2005	
	10		30. Name and address of person who	to 1 An inid		111 Pe	nn Street	Balti	more,	Maryla	ınd 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	20					
	Registr		MAY 1 0 2005	Blown 15 1	1						
DI	HMH 17 Pay 1/2	301									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 3:30A.M OM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner noeni If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday)
Yrs. 6. Sex 10 M 2 ☐ F **Funeral** Days Months Hours Director Usuat Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, 10a State 10h Count 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at Be Completed by Funeral Director 1 ☐ Yes 22 No Marylana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (1c 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 200 Specify: Whi WWIL 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Vehicle Maintenance Foreman Balto. Co. Fire Dept. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) enc 2 19b. Mailing Address (Stre. and Number or Rural Route Number, City, & Town, State, Zip Code) 10 reeland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location Department of F Important: If its any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ter the disease, or complication heart failure list only one cay that caused the death. Immediate Cause (Final Physician las la disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2**X**No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 25 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📉 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural after death. 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

DHMH 17 Rev 1/200

within 2 To the

> State Registrar

2005 MAY 10

30. Na ne and address of person who completed cause

29b. Signature and title of certifier

and manner stated.

23a) (Type, Print)

	1	For State Registrar	State of Mary	_	artment of Health and rtificate of Death		Jiene () ()	5 565
cian lical		1. Decedent's Name (First, Middle, Thomas Ja. Facility Name (If not institution,	Francis	Brow	4b. City, Town, or Location of Deat	2. Date of Dea	Day 20	3. Time of Death
iner		2 Latimer	- Court	yrs. last birthday	Rosedale If Under 1 Year If Under 24 Hrs		Baly	9. Birthplace (State or Fore
r	-	Usual Residence of Decedent	0	8 Yrs.	Months Days Hours Min.	May S	1917	Scranton, Fr
actor	١.	Maryland Balt	Smore Co.	C. City, Jown or L ROSE	lale		0.00	10d. Inside City Lim
Funeral Director		2 Latimer	Court 12. Was Decedent Ever	in H C 12	10f. Zip Code 2/23/7		10g. Citizen of W	e - American Indian,
4 by Fune		11. Marital Status 1 □ Never Married 2 □ Marrie 3 Widowed 4 □ Divorced	Armed Forces?	110.3.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes	to Rican, etc.)	Specify.	k, White, etc.
Completed by		15. Decedent'. (Specify only highest Elementary/Secondary (0-12)		(Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) CALMAN	rking	Penn.	siness/Industry Railroud
To Be C	1	17. Father's Name (First, Middle, L James	Brown	1	18. Mother's Na EI/e	me (First, Middle,	Majden Sumami	θ)
	1	19a. Informant's Name/Relationsh	Grabowsk	19b. Mail 526 0b. Place of Disp		ld. Rose	edale,	State, Zip Code) MD, 21237 City gr Town, State
		20a. Method of Disposition 1 □ Burial 2 Cremation 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	3 □Removal from State ecify)	EVANS F	ematory or other clase) Wera (Chaps Ma)	v 6,2005	Fore:	st Hill, M.
8300		Jepley of	gar, Dr		2325 YOOK P	atives 1	unital	MD. 210
n		23a. Part 1. En er the disease, or disease, or disease, or heart fail re. List of	only one cause on each line.	death. Do not er				
al		Immediate Cause (Final disease or condition resulting in death)		clerotic	candiovascula			Interval Betweer Onset and Deat
il r		disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	_ A+terioso	electic insequence of):				Onset and Deat
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hy Physician/Medical Examiner	by Filysicial medical Examine	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a co	nsequence of): nsequence of): regnancy Fetal death 3 of death 5	Candiovascula	23e. Did to	23d. Date Mor	e of delivery the Day Year
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	Е	Physici	ian	1. Decedent's Name (First, Middle, Earl Herbert Ba	•				2. Date of Death Month	Day Year	3. Time of Death		
		/Medic Examir		4a. Facility Name (If not institution, s	give street and number)			or Location of Death		2005 4c. County of Death Balt	8:25 P M imore Co.		
		Funeral Director		218-28-8549	. Sex 7. Age (In yrs. last birthda 72 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) April 21		place (State or Foreign intry) yland		
		Maryland a-f show	ctor	Usual Residence of Decedent	/A 1	Oc. City, Town or	Location Baltimore	2			10d. Inside City Limits 1 ⊠X es 2 ☐ No		
		h with the	al Dire	10e. Street and Number 3939 Roland Ave	enue Apt. 10	01	10f. Zip Code	212		g. Citizen of What Cou	usa		
	036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 le marked other then "naturel', or items 23a or 28a-1 show any injury or other treumatic event, it is Medical Exar in act mast be rollified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? **XXYes 2 □ No If Yes, Give 19 Year or Dates.		3. Was Decedent of Hif Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W.			
р.ш.	Baltimore, Maryland 21215-0036	i within 72 ho iene. r then "nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat cutter 18. Mother's Name (First, Middle, Last)							•		
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		fter Ine	Certification; T	To inpatient 2 Devocupation 3 DOX 4 Noting Home 5 Residence 6 Mother (Sp.									
i	DIX	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, s Specify)	street, factory, office	1	28f. Location (Stree City or Town, S	t and Number or Rura State)	l Route Number,		
		he Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	hysicien: To the best of mominer: On the basis of examiner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)		
		o d with	Σ.	29b. Signature and title of centifier	-6		29c. License	9 number 4372	29d.	Date signed (Month, 1	Day, Year)		
	_	51		30. Name and address of person who DR. TARIQ MAHMO			e, Print)	LIMONTIM	MD 21002				
		Stat Registra		31. Date filed (Month, Day, Year) MAY 1 0 2	33 Registrar's	Signature	north						

DHMH 17 Rev 1/2001

MAY 8, 2005

EARL BAKER

		Please Ker Jr. 1- State Registrar	otato of mary	C	ertificate of	Death		giene U	15656			
Dhusi	ion	Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	ath	3. Time of Death			
Physic /Med		Rodney K. Booker,					April	30 20	05 1325 ^			
Exami	ner	4a. Fecility Name (If not institution, gi	ve street and number)			r Location of Death		4c. County of				
Funeral		Harbor Hospital 5. Social Security Number 6.	Sex 7. Age (In)	rs. last birthda	Baltin Baltin	T	8. Date of Birtl	Baltimore City irth (ay, Year) 9. Birthplace (State or Foreign Country)				
Director			1\\\ M 2□F	Yrs.	Months Days	Hours Min.	(Month, Da)	fonth, Day, Year) Country)				
and		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location		2004 Mississippi 10d. Inside City Limits					
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f show ent. Its Macilcal Examinat must be notilised at	ō		mund o 1						1 ☐ Yes 2 ☑ No			
th the or 28a	Director	10e. Street and Number	<u> </u>	en Bur	10f. Zip Code			10g. Citizen of Wha	at Country?			
ath wit		115 Warwickshire	Lane, Apt. B	3	21061			USA				
er deg	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 1:	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spean, Mexican, Puerto F		14. Race -	American Indian, White, etc.			
irs aft	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: B	lack			
2 hou		15. Decedent's E	ducation	16a. De	cedent's Usual Occup	pation		16b. Kind of Busin	ness/Industry			
d within 72 ho piene. r than "natu	Completed	Elementary/Secondary (0-12)	(Give kind of work done during most life. DO NOT use retired) Infant				ig	27 / 4				
filed withi Hygiene. other than		17. Father's Name (First, Middle, Las	21	10 Mothodo Name	(Figs. 1 dialoll-	N/A						
G d ai	To Be	Rodnev K. Booker				18. Mother's Name						
should Ind Menia s marke	-	19a. Informant's Name/Relationship		19b. Ma	ailing Address (Street	Shalisaka and Number or Rural			ate, Zip Code)			
		Shalisaka Gillia	m-Mother		Warwickshi							
of He		20a. Method of Disposition 1 X Burial 2 Compation 3 [b. Place of Dis 	sposition (Name of rematory or other place	Da	ate	20c. Location - Cit				
permit. Pages Department of I Importent: If Ite any injury or of		'4 □ conation 5 □ Other (Special	fy) A G	len Hav	ven Mem. P	ark May 6,	2005	Glen Burn	ie. MD			
permit. Pages 1 ar Department of Hea Importent: If Item any injury or other once.		21. Signal y e of Furn ral Service Lice	1 600 · 1	H	22. Name and Addre Kirkley-Ru	ss of Facility ddick Fune	eral Hor	me. P.A.				
		23a. Part1. Enter the disease, or con	nolications that caused the d		421 Crain	Hwy, S.E.	Glen B	urnie, MD	21061 Approximate			
Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				respiratory an		Interval Between Onset and Death			
/Medical		disease or condition resulting in death)	a. Suttlen Unexp			Ly						
Examiner		Sequentially list conditions,	b									
Bd isi	xamlnei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):								
executed and al-transit	Exan	that initiated events resulting in death) Last										
tificate be exign physicien as the buria												
tificat ng phy as th	ledi	1										
The law requires that the death certificate be exite has been signed by the attending physicien bage 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	gnancy etal death	3 □Ectopic pregnancy	,		23d. Date of	,			
ne dea the at hed fo	/sici	1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	of death 5	Other (specify)	<u> </u>		Month	Day Year			
res that the digned by the be detached	/ Ph	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?			
quires n sign ald be	d by				, , ,		1 🗆 Y	es 2 □ No 3 □	Probably 4 □Unknow			
s been s should	olete						24a. Was a	ın 24b. Wer	e autopsy findings availabl			
he tav e has	Completed						autops	sy prior med? deat	to completion of cause of			
→ ate	BeC	25. Was case referred to medical examiner?				26. Place of Death	- 1	2 □ No 1/2 ne)				
cien: T artificate ctor, pa	은	1X Yes 2 No			ient 3 DOA Othe	4 Nuising Hom		ence 6 Other (Specify)			
Physicien: The this certificate al director, pag	1 00	27. Manner of Death 1 □Natural 5 □ Pending	28a Date of Injury Un Month, Day Year	28b, Time Unknjury	/ Worl	Van OMNA		ow injury occurred				
ding Phyeicien: h. After this certifica	tlon	2 Accident investigation 3 Suicide 6 Could not be	e 28e. Place of Injury - A	t home, farm		184	rk Bf. Location <i>(St</i>	treet and Number o	r Rural Route Number,			
iing Phyeicien: n. After this certifica funeral director, p	flcation		building, etc. (Spe	ecify)	,,,		City or Town	n, State)	, , , , , , , , , , , , , , , , , , , ,			
ding Phyeicien: After this certifica	ertification	4 ☐ Homicide determined	unk		ath accurred at the time	ne date and place ar	nd due to the c	ause(s) and manne	r as stated.			
ding Phyeicien: After this certifica	cal Certification;	29a. Certifier 1 Certifying Pi	nysicien: To the best of my	knowledge, de	invectionation in the lin	ninian dansh		are and place, and	alore to the state of the			
ding Phyeicien: After this certifica		29a. Certifier 1 Certifying Pl		knowledge, de iination and/or	investigation, in my or	pinion, death occurred			due to the cause(s)			
or Attending Physicien: Iter death. Director: After this certifics in by the funeral director, p	Medical Certification	29a. Certifier 1 Certifying P	nysicien: To the best of my l miner: On the basis of exam	knowledge, de iination and/or	investigation, in my of	pinion, death occurred		9d. Date signed (M	due to the cause(s)			
ding Phyeicien: After this certifica		29a. Certifier (Check only one) 29b. Signature and little of certifier	nysicien: To the best of my liminer: On the basis of exam and manner stated.	ination and/or	29c. License	pinion, death occurred	2		due to the cause(s) fonth, Day, Year)			
ding Phyeicien: After this certifica		29a. Certifier (Check only one) 29b. Signature and little of certifier	nysicien: To the best of my l miner: On the basis of exam	ination and/or	29c. License	pinion, death occurred e number	2	May, 1, 2	due to the cause(s) fonth, Day, Year)			

			1 - For State Registrar	State	of Maryla	and / Depa	artment <i>rtificate</i>			and M	_	gieme	05	15657	
			1. Decedent's Name (First, Middle	, Last)						-	2. Date of De.	ath		3. Time of Death	
	Physici /Medi		Geraldine E	thel Car	ter						Month Mav	Day 5	2005	10:20A M	
	Examir		4a. Facility Name (If not institution	, give street and	number)		4b. City, T	own, or	Location of	f Death		4c. Cc	unty of Deat		
			Gilchrist				Γ	ows	on			I	Baltim	ore	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2X F		rs. last birthday)	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birt	hplace (State or Foreign	
	Director		219-03-0034	1 L W 2 2 1	8	34 Yrs.	1 0				Nov. 1			yland	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits	
	Maryl f sho	ō	Maryland Ba	ltimore		Ozzámon	M411 -						10d. Inside City Lin		
	the 1	Director	10e. Street and Number	rtimore		Owings	10f. Zip C		100				1 ☐ Yes 2:		
	3a or	Ö	9 Five Oaks Co	nurt			21117						and y		
	ms 2	Funeral	11. Marital Status	12. Was D	ecedent Ever in	n U.S. 13.	Was Decede		_ :	rigin? (Specify Yes or No-			U.S.A. 14. Race - American Indian.		
9	after or ite		1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Ye	Forces? s 2 🔀 No		. Was Decedent of Hispanic Origin? (Specify Yes or the Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:						Black, White	e, etc.	
8	hours after death with the Maryland turat', or liems 23a or 28e-f show at Examiner must be notified at	by	3 ☑ Widowed 4 □ Divorced	If Yes, Year or	Dates:		I∟IYes 2]	⊠ No	Specify:			Sp	ecify:	White	
21215-0036	72 h	Completed by	15. Decedent (Specify only highes		d)	16a. Dece	dent's Usual kind of work	nt's Usual Occupation nd of work done during most of working O NOT use retired)					of Business/	Industry	
21	ithin ne.	d L	Elementary/Secondary (0-12)	T	(1-4or 5+)						9				
	fled w flygie her t h. Ih	Be	8 17. Father's Name (First, Middle, I	(cat)		Del	i Mana		40.14.11		/=:		d Ser	vice	
Maryland	ntal F		William Fred		. 1						(First, Middle,		mame)		
Ž	hould d Me mark mark	P P	19a. Informant's Name/Relationsh		ennert	10h Mailie	a Address /	Ctanna			ine Sac				
Ma	d2s than trau		William F. Carte		`										
ē,	o-rmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28e-f show and highly or other traumatic event, the Madical Examinator must be notified at pins.		20a. Method of Disposition	1 (2011		b. Place of Dispo	ve Oak sition (Name	of			ngs Mil		lary Lai ion - City or	nd 21117 Town, State	
υQ	ages ant of it: If ii		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			cemetery, crer	•		1	F 0	2005				
Baltimore,	p-rmit. Pa Departmen Important: any injury		21. Signature of Puneral Service L	_	1	oudon Pa	Name and	Addross	of Engilit					Maryland	
ď	Depar Impor any ir		Dinner	Nal	recht	W:	itzke 530 Fd	Fune	eral	Home	ofCato Cator	nsvil	le, In	nc. 21228	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications tha	t caused the d	eath. Do not ent	er the mode	of dying	, such as	cardiac c	r respiratory ar	rest,	e, m	Approximate	
	Physician		Immediate Cause (Final disease or condition	only one cause of	-	1000								Interval Between Onset and Death	
	/Medical		resulting in death)	aDue t	o (or as a cons	Sequence of):					-			CATS	
	Examiner		Conventiolly list and time	b	GA	rane	ne.	01	42	sat	-			weller	
	_ ^ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or s a cons	sequ + ce of):		0		7	disense				
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	per	aphel	7()	/AS	300	low	dise.	ASC		years	
8760,	oe ex		resolding in death) Last	Due t	o (or as a cons			20	11	-1					
87	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 sht uid be detached for use as the burial-transit	dlcal		d	1)1	H 5e1	es 0	116	911	c + c	<u>د د</u>			gears	
×	it the death certific by the attending p tached for use as	0	IF FEMALE:	220 If yes	outcome of pre	anana.		-							
Box	atten for us	lan	23b. Was decedent pregnant in the past 12-months? 1 \(\sum \) Yes 2 \(\sum \) No	1 Live	birth 2 ☐F gnant at time o	etal death 3	Ectopic preg					23d	. Date of deli Month	very Day Year	
o.	the de	Physician/M	1 Yes 2 No 9 Unknown	9 Uni		ordeath 5	Other (spec	:ny)				ĺ		•	
Q	res that i igned by be deta		Part II. Other significant condition	ns contributing to	death but not	resulting in the ur	iderlying cau	se giver	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	
Records,	quires n sign	d by	COVONANY	AV 4	214 d	DeASE					1 □ Y	es 2ÔN	o 3 Pro	bably 4 Unknown	
S	w requir been si should	lete	CongeAn	e He	art	fail.	310			_	24a. Was a	20 2	4h Were aut	topsy findings available	
Re	he lav e has age 2	Completed	00/000	-		3//6 -					autop: perfor	sy med?	prior to c death?	ompletion of cause of	
Vital		a)	25. Was case referred to medical	- Cuc					as Place	of Dogsth	(Check only or	2 No	1 🗆 Yes	2□ No	
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	□ ER/Outpatien	3 DOA	Other	-		ne 5□Resid		Other (Spec	the Harrison	
ı of	ding Phys .r After this funeral di		27. Manner of Death	28a. Dat	e of Injury onth, Day Year,			: Injury			28d. Describe h			" I Copera	
0	ath. r: Afr	atlo	1 Natural 5 Pending 2 Accident investig	ation	nin, bay roar,) Injury	М		es 2 🗆 N	io					
27. Manner of Death 1									2	28f. Location (S City or Town	treet and Ni	umber or Ru	ral Route Number,		
	itel o rs aft ral Di	27. Manner of Death Control Cont													
	Hosp 24 hou Fune fely fil									stated. to the cause(s)					
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Young)															
	8 30. Name and address of person who completed cause of death strong 23a) (Type, Print) W. A. Riley G. Byn (670) N. Charles St. Balts and 2								· _ ·						
	84	-	30. Name and address of person v	no completed ca	use of death (4	1 (Tyne	Print)	1	300	0 0		N/ IT	7 1	2003	
_	0		W.A.R	iley	68	mc	670	21	N.	Cla	arles	T.B	alt.	Md 21 20x	
	Sta Registr		31. Date filed (Month, Day, Year)	WAY 1 032	Registrar's Si	hature	B. A	034	0						
	2,12,11	v 04	· ·		7		0								

			1 - For State Registrer	State of Marylar		rtment of H			giene ()5	156	58	
			Decedent's Name (First, Middle, Last)					2, Date of Dea	ith		3. Time of D	Death	
	Physici /Medio		Clyde Richa	rd Carpen	ter			Month M 4V	Day	Year 2005	1615	M	
	Examin		4a. Facility Name (If not institution, give si		14		Location of Deat	1	4c. County	of Death			
					eal Cente		iltimore		1	1/1			
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	(Year)	Coun		Foreign	
	Director		Usual Residence of Decedent	71	115.			Nov. 28	,1933	Mar	yland		
	yland		10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				1	0d. Inside City	Limits	
	Mar.	tor	Maryland Washingt	on Ha	gerstow	Tì					1 ☐ Yes 2	2 X No	
	or 284	Director	10e. Street and Number			10f. Zip Code		1	l 0g. Citizen of V	Vhat Cour	itry?		
	th wil		20217 Robin Wood C	ourt Apt. 60	3	21	742		United	Stat	.66		
	ams	Funeral		Was Decedent Ever in U Armed Forces?		as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race		an Indian,		
36	or It	by Fu	1 Never Married 2 Married	1 XYes 2 No	1	□Yes 25t No	Specify:	0 7 110 22 11 0 (0.5)	Specify	,.			
8	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ehow Jical Exercities Innet be redified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates: Kore						Wh	nite		
21215-0036	in 72 n na n na	Completed	(Specify only highest grade	completed)	(Give k	ent's Usual Occupa ind of work done o O NOT use retired	during most of wor	king	16b, Kind of Bu	siness/fno	lustry		
212	liene.	mo	Elementary/Secondary (0-12)								e		
פ	e filec othe vant,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I					
<u> la</u>	uld b Ments Irkad Itic a	To E	Clarence Stanley C	arpenter			Jessie	Virginia	Main				
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Street a	and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)		
2	and ealth m 27 har tr		Beatrice M. Carpen		20217	Robin W	ood Cour					2	
O.	ges 1 t of H If ita or ot		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Re		Place of Dispos cemetery, cremi	ition (Name of atory or other place	e) May	Date 3,2005	20c. Location -	City or To	wn, State		
Baltimore,	t. Pa rtmen rtant: njury		`4 □Donation 5 □Other (Specify)			tan Crem	atoriun		Alexand:	ria,	Virgin	ia	
Bal	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportant: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic avant, the Medical Evantinet mast be radified at once.		21. Signature of Juneral Service License	111	01	Name and Addres	lesworth	P. A. Fu	uneral H	Home			
			23a, Part1, Enter the disease, or complig	ations that caused the deat		401 Ridge				and 2	20872 Approximate		
	DI		23a. Part1. Enter the disease, or complice shock, or heart failure. List only only Immediate Cause (Final	Λ , /				or respiratory arre	531,		Interval Betwe Onset and De	en eath	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		neumon	10		Onset and Death				
	Examiner			240 10 (0) 45 2 00,000	017.								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8760,	ficate be executed physician and is the burial-transit	E	resulting in doubly East	Due to (or as a conseq	uence of):								
	physicate s the	dical	d.							-			
Box (certif nding use a	√Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna	ancy				23d Date	of delive	21		
ă	death a atte	Iclai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		ctopic pregnancy Other (specify)			Mon		Day Yea	ar	
0	t the by the tache	Physician/Me	9 Unknown	9□ Unknown									
S,	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	by P	Part II. Other significent conditions control	Δ,	ulting in the und	lerlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the	a cause of dea	ith?	
Record	w requir been si should		Chronic Obstructi	re hulmonar	y DIS	euse		1 ☐ Ye	s 2 No	3 Proba	ably 4 ∐Unk	known	
ec	e law r has be	Completed	teri-operative M	youardual I	nfaveti	21		24a. Was ar		ere autop	sy findings ava	ailable	
H	: The lav	Con	Thoraco-Andona	121 Aartic.	Aneury	sur.		perform 1 ☐ Yes 2	ge g ? de	eath?	2□ No		
Zi Ki	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital: 🗸		Otho		th (Check only on					
o	Phys r this ral dir	- To	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA Othe	4 🗀 Nursing H	ome 5 Reside)		
on	th. After this funeral of	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2 □No	20d. Describe no	w injury occurre	u			
Division of Vital	Attar r dea actor by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho	ome, farm, stree			28f. Location (Str	reet and Numbe	r or Rural	Route Numbe	ır,	
ā	s afte	Certification:	4 Homicide	building, etc. (Specif	V)			City or Town	, State)				
Natural 1 Natural 2 Describe now injury occurred 1 Natural 2 Describe now injury occurred 1 Natural 2 Describe now injury occurred 2 Describe now injury oc							use(s) and man	ner as sta	ited.				
							d. Date signed						
•	AL.		K. Bulde	MA MA		15	770		May 2	700) フ		
	14.		30. Name and address of person who com	pleted cause of death (Item	1 .		0 .1 -						
	Stat	e		Registrar's Signa		enter 22	South Gr	eene Str	eet, Ba	ltimo	re, MD	-	
	Registra	-	31. Date filed (Morth, bay, Year)	Marine to		er.							

			1 - State of N	laryland		artment <i>tificate</i>			and Mental		ene 0 0	5	5659	
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)						2. Date	of Death	Day	Year	3. Time of Death	
	Physici /Medic			geline	R. Co	le			May		4 200		7:30p M	
	Examin	er	4a. Facility Name (If not institution, give street and number			4b. City, To	own, or	Location o	f Death		4c. County	of Death		
			Kensington Park Retirement 5. Social Security Number 6. Sex 7. A	ge (In yrs. la:	et hiethelaul	If Under 1	Kens	ingto		of Diets	Mo	ntgo		
	Funeral Director		027-10-7873 1□M 2⊠F	87	Yrs.		Days	Hours	Min. (Mon	th, Day, 1	(ear)	9. Birth	place (State or Foreign ntry)	
	D		Usual Residence of Decedent						Dec.	14,	1917	mas	sachusetts	
	arylan show	_	10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits	
	Ba-f	Director	Maryland Montgomery	Dama	scus					100 000			1 ☐ Yes 2 🛣 No	
	with th		10e. Street and Number			10f. Zip C						itizen of What Country?		
	eath is 23	erai	10932 Bellhaven Blvd. 11. Marital Status 12. Was Deceder	t Ever in II S	12.1	20872					United			
'	fter d	Funeral	Armed Forces 1 Never Married 2 TMarried 1 □ Yes 2 5	?	13. 1	Yes, specify	Cuban	, Mexican	nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
93	ral', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	:	,	☐ Yes 25	₫ No				Specify	· wł	nite	
5-0	be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "natural", or Itams 23a or 28a-f show event, the Maryland Ever ill at triant by mullised at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	lent's Usual (Occupat	tion	of working	16b Kind of Bu			dustry	
21	vithin ne. han	mpļ	Elementary/Secondary (0-12) College (1-4o	5+)	life. L	OO NOT use	retired)			N	ationa.	1 In	stitutes	
2	filed v Hygie othar t		12 17. Father's Name (First, Middle, Last)		Exec	utive			ry r's Name <i>(First, N</i>		f Heal			
ano	d be f) Be									uden Surnam	θ/		
Maryland 21215-0036	2 should be and Mental la marked or aumatic even	To	William Cundall 19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address (5	Street ar		e1 Unkno r or Rural Route I		City or Town	State Zir	Code)	
Š	nd 2 alth ar 27 la		Bette Hurst/ Daughter	1					d. Dama					
e,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Itam 27 la marke any injury or other traumatic gnes.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name natory or othe	of er place		Date	20	c. Location -			
Ē	Page nent c int: If iry or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	9				10	une 3,20		rlinet	on.	Virginia	
Baltimore,	permit. Departr Imports any inju		21. Signature of Juneral Service Licensee)	Arlington National Cemetery 22. Name and Address of Facility Olin L. Molesworth P.								, 11, 511114	
_	90 E # 9		Sad Dayw		26	401 R:	idge	Road	d, Damas	cus.	Mary1a	and	20872	
г			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. line.	Do not ente	or the mode of	of dying,	such as o	cardiac or respirat	ory arres	t.		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	nger	Hive.	Hes	rot	te	silvne				Onset and Death	
	/Medical Examiner		Due to (or a	s a donseque	ence of):	1	200	()	(do noe!	φ				
		-e	Sequentially list conditions, if any, leading to immediate	s a conseque	ence of):	400	0) C	V	JONOSI	·		-		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sonos		ast	my	(disease					
ó	an an rial-tr	Еха		s a conseque	once of):		0							
8760,	ficate be executed physician and is the burial-transit	dicai	(d	pest	ensse	en,								
9	ing ph e as t	Med	IF FEMALE:	-										
Вох	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 Fetal d	leath 3	Ectopic preg					23d. Date Mon		ory Day Year	
o.	he de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant : 9 ☐ Unknown 9 ☐ Unknown	it time of dea	ith 5∐	Other (speci	ify)						Day Tour	
<u>α</u>	res that the di	/ Ph	Part II. Other significant conditions contributing to death	but not result	ing in the un	derlying caus	se given	in Part I.	23e.	Did tobac	cco use contri	bute to th	ne cause of death?	
Records,	luires r sign	d by	Atrial Librillation.				•			1 🗌 Yes	2 X No	3 🗌 Prob	ably 4 Unknown	
000	w requires been si should i	olete	()						24a.	Was an	24b. W	lere auto	psy findings available	
	The lay te has age 2 :	Completed	V						_ _	autopsy performe	d? di	rior to cor eath?	npletion of cause of	
Vital		0	25. Was case referred to medical					26. Place	of Death (Check		No 1	Yes	2 No	
_	phyaic this ce al direc	ToB	examiner? 1 ☐ Yes 2 XVo Hospital: 1 ☐ Inpat	ent 2 Ef	R/Outpatient	3□ DOA	Cther		sing Home 5		e 6 □Othe	r (Specify	()	
n of	ding Pl h. After ti funera		27. Manner of Death 126Natural 5 □ Pending (Month, D	ay Year) 2	8b. Time of Injury	28c.	Injury a Work?	at			injury occurre			
Sio	tend leath tor: /	cat	2 Accident investigation			М		s 2□N						
Division	I or Attendate after death Diractor:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St. City or Town								et and Numbe State)	r or Rura	l Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after dealth as a fire dealth or for the Funeral Director: Attent his certified completely filled in by the funeral director,		29a. Certifier Certifying Physician: To the bes	of my knowl	edge death	occurred at t	he time	date and	place and due to	the caus	se(s) and man	nor as st	atod	
	a Ho	Medical	(Check only one) Medical Examiner: On the basis and manner s	or examination	n and/or inv	estigation, in	my opir	nion, death	occurred at the t	ime, date	and place, a	nd due to	the cause(s)	
	To the Hospital within 24 hours a To the Funeral Completely filled	ŭ	29b. Signature and title of certifier			29c. L	icense r	number	`	29d.	Date signed			
)			1 My My ledy			1	3	369	(1	nay	5	. 2005.	
	5,		30. Name and address of person who completed cause of	-		,								
	l		Ajay Reddy M. D. 6320 Dem				esda	a, Ma	ryland 2	0817				
	Sta Registra	_	31. Date filed (Month, Dal), Year) 32/Regist	rar's Signatur	Age	Me !								

_			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H rtificate of L			giene () ()5	156	60
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last)	George	W. (Cundiff		2. Date of Dea Month May 9,	2005	Year	3. Time of I	
	Examir		4a. Facility Name (If not institution, give s Home; 1440 W. 36th	Street		Balti			4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Sex 236-42-6003	7. A	nge (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Aug 26	, Year) 1923	9. Birthi Coun Kent	place (State or ntry) :ucky	Foreign
	e Maryland ta-f show	ctor	10a. State 10b. County Maryland N/A		10c. City, Town or Lo	Baltimor	·e			1	10d. Inside City	•
	th with th	al Director	10e. Street and Number 1440 W. 36th Stree	t		10f. Zip Code	21211		10g. Citizen of \		ntry? ISA	
980	urs after dea el', or items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	12. Was Deceder Armed Forces XIX Yes 2 If Yes, Give Year or Dates	9?]No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes ※※ No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Bfac Specify	ck, White,	can Indian, etc. white	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "naturel", or items 23a or 28a-f show event, I'm Medical Evaruli er must be notified at	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0·12)	cation completed) Colfege (1-4o	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired, 1wright	luring most of work	ing	16b. Kind of Bi		_{dustry} nufacti	urinc
land 2	be filed tal Hygi d other	To Be Co	unknown 17. Father's Name (First, Middle, Last) Elmer Cundiff		1111	Twitght	18. Mother's Name Clara G				IIuIacci	ur riig
e, Mary	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty) Diana Schluderberg 20a. Method of Disposition			M. 36th	Street		ore, Man	ylan	d 2121	1
Itimor	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau QDC8.		1 Donation 5 Other (Specify) 21. Signar Peral Service Lyense		Baltimore	natory or other place -Washingt	on 5/10,	/2005		L, Ma	ryland	
Ba Ba	Dep Imp		23a. Part Enter the disease, or complishock, or heart failule. List only on	lupu	30	2. Name and Addres Ingee-Hens 531 Falls er the mode of dying	road p	altimor	e. Marv	Inc. land	21211 Approximate	
	Pnysician /Medical		Immediate Cause (Finaf disease or condition resulting in death)	CORO	s a consequence of):	ETERY	DISER	A			Interval Betwo	
8760,	icate be executed physician and physician and street transit	dlcal Examiner	Sequentially list conditions, Lay leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Death (or a	s a consequence of):							54
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of delive	•	əar
Records, P.	w requires that been signed b should be deta	by	Part II, Other significant conditions con	tributing to death	but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tol	bacco use contres s 2 No		ne cause of dea	
Vital Rec	icien: The law certificate has b ector, page 2 st	e Completed	25. Was case referred to medical						ned?	Vere autoprior to confeath?	psy findings av npletion of cau 2 No	/ailable use of
Division of Vit	ding Phys h. After this funeral dii	ToB	examiner?	ospital: 1 lnpat 28a. Date of Inj (Month, D	ury 28b. Time of	t 3 DOA Other	4 Indising nor	/	ence 6 Othe		1)	
Divis	Dig to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, e	njury - At home, farm, str tc. <i>(Specify)</i>			28f. Location (St City or Town	n, State)			∋ <i>r</i> ,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in h	Medical	one)	er: On the basis and manner s	t of my knowledge, death of examination and/or inv tated.	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the ca	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)	
	vitt von	~	29b. Signature and title of certifier Mada Ku	wau		29c. License	number 046783	2	9d. Date signed 5/9/6	1 (Month, 1	Day, Year)	
_	Ve		30. Name and address of person who con	Baltin	nove MD	Print)						
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 20	32. regist	trar's Signature	ande						

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I rtificate of			iene 0 0 5	15661
	Physici /Medi		Decedent's Name (First, Middle, La HELEN ELAT	•	C			2. Date of Death Month May	8, 2005	3. Time of Death 2:50 P. M
	Examir		4a. Facility Name (II not institution, given Manor Care Ruxto	on		Tows			4c. County of Death Baltimo	
	Funeral Director			Sex 7. Age	(In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 1,	Year) Cour	place (State or Foreign htty) Sachusetts
	Maryland	tor	10a State 10b County Maryland Baltin		10c. City, Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2X No
	with the	i Direc	10e. Street and Number 151 Versailles	Circle		10f. Zip Code	204	10	g. Citizen of What Cour	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other traumatic event, it is Nedical Examina must be retified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 \(\text{Yes} \) 2\(\text{No} \) No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub		pecify Yes or No- o Rican, etc.)	U.S.1 14. Race - Americ Black, White, Specify: Whi	an Indian, etc.
212-0	thin 72 ho e. en "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	6b. Kind of Business/Ind	
d 21	be filed wintal Hygien of other the event, Ital	Be Con	17. Father's Name (First, Middle, Last	2 years	,	Homema		ne (First, Middle, M	Own Home	
ırylar	should be and Menta s marked umatic ev	ToB	Arthur W. 19a. Informant's Name/Relationship (nons	na Address (Street	Maude		ocke City or Town, State, Zip	0.75
Baltimore, Maryland 21215-0036	s 1 and 2 s f Health ar item 27 ls other trau		Meredith Chase Bo	ren (daugh	ter) 508	Limeric	c Circle	Timoniur	n, <u>Maryland</u> Oc. Location - City or To	21093
altimo	permit. Pages Department of I Importent: If it any injury or or		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speciformation 5 ☐ Other (Speciformation 5) ☐ Oth	(y)	Druid Ric	natory or other place. Ige Cemet Name and Addre	erv 5-1	11-05 P	ikesville,	Maryland
Ä	Dep Imp		Sevye F 23a. Part 1. Enter the disease, or com	endre	No death De set est	Mitchell- 6500 Yor	Wiedefeld k Road I	l Funeral Baltimore	Home, Inc.	21212
	enysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Athen		or the mode of dyn	ng, socii as cardiac	or respiratory arres)ijeare	Approximate Interval Between Onset and Death
	physician and physician and sthe burial-transit	Examiner	Sequentially list conditions, I ary the sequentially list conditions, I ary the sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Die to (or as a c	consequence of):					
68760	death certificate be executed e attending physician and d for use as the burial-transit	dical		_ d						
.O. Box	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
rds, P	The law requires that the te has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	1	cco use contribute to the	
al Record		Completed						24a. Was an autopsy performe	prior to com	sy findings available apletion of cause of
of Vital	ig Physicien: The ter this certificate ineral director, page	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	t 3 DOA Other	er: 4 Nursing Ho	th (Check only one) ome 5 Resident 28d. Describe how	ce 6 □Other (Specify,	7-80-1-6059
Division	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	1	- At home, farm, stre	M 1□	Yes 2 □No	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
1	e Hospitel or 24 hours afte e Funerel Dir letely filled in	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysician: To the best of r	camination and/or inv	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the cau	sa(s) and manner as etc	ited. the cause(s)
	To the Hos within 24 hr To the Fun completely	Med		and mailing states	u.					
	0 '		30. Name and address of person who of TARIA MARK	completed cause of deal	th (Item 23a) (Type, I	Print) Back 1	river "	reck R	you Mal	timero
	Sta Registra		31. Date filed (Month, Day, Year,	1 0 2005	Ignature	foots			Date signed (Month, D	

	1	State of Maryland / Department State State Registrar State Of Maryland / Department Certificate Certificate	nt of Health and M te of Death	_	ene 0 0 5	15662
Physician /Medical		Decedent's Name (First, Middle, Last) BARBARA ELLA COOK		2. Date of Death Month MAY 6,	Day Year 2005	3. Time of Death 7:30a M
Examiner	ľ	2302 CLOVILLE AVE. B	, Town, or Location of Death ALTIMORE or 1 Year If Under 24 Hrs.		4c. County of Death	
Funeral Director		5. Social Security Number $219-26-9300$ 6. Sex $1 \square M$ 2 $\square XF$ 7. Age (In yrs. last birthday) If Under Months Usual Residence of Decedent		8. Date of Birth (Month, Day, Y 5-6-1938	Year) 9. Birth Cor 8 MARY	pplace (State or Foreigr untry) 'LAND
Baltimore, IMaryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Evantment mast be could also TO Be Completed by Funeral Director		2302 CLOVILLE AVE. 2	p Code 11214 sident of Hispanic Origin? (Specify Cuban, Mexican, Puerto		J. Citizen of What Cor USA 14. Race - Amer Black, White Specify: BI	ican Indian,
ind Z I Z i 3-0036 be filed within 72 hours aft lai Hygiene. d other than "natural", or event, the Medical Event Be Completed by F	- Landing	15 Decedent's Education 16a, Decedent's Usu	ork done during most of work use retired)	ing	GENERAL MC	,
Baltimore, Maryland permit. Pages 1 and 2 should be fil. Department of Health and Mental ty Important: If Item 27 is marked oth any injury or other traumatic even angue. To Be	2		S (Street and Number or Run DVILLE AVE. BA	ALTIMORE,		21214 Town, State
Danit. P Departm Importar any inju		21. Signature of Emeral Service Licensen ONATHAN D. HIBNER 2. Name a	and Address of Facility PHI			
S 7 60, aate be executed Take burial-transit The bu	100	23a. Part 1. In fer the disease, or complications that caused the death. Do not enter the mo shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Hugh Rush W. Due to (or as a consequence of): Due to (or as a consequence of):	g desease	lly	i,	Approximate Interval Between Onset and Death Grant Control of the
ath certific ath certific or use as	ysicializme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deline	very Day Year
HeCOIGS, The law requires the has been signed age 2 should be demonstrated by	2	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	1 Yes 24a. Was an autopsy performe	prior to c	obably 4 Dinknown topsy findings available ompletion of cause of
ding Physician After this certific funeral director	200	25. Was case referred to medical examiner? 1	OA Other: 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	h (Check only one) ome 5 P Resident 28d. Describe how	ce 6 Other (Special injury occurred	ify)
Hospita Hospita Hours Funeral tely filled	פוכפו	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred and manner stated. 29a. Certifier (Check only one)				
To the within 2 To the comple	DE .	29b. Signature and title of certifier	OCTO93	290	1. Date signed (Month	
State Registrar		MARGARET MORON UNION MEMORIAL HOSPITA 31. Date filed (Month, Day, Year) 0 2005 32. Restrar's Signature (MAY 1 0 2005)	L BALTIMORE,	MARYLAND	21218	

CFM 05-03154 Shirlena Davis

rıen	a Davi	S	1- For Unpend Item 23a&27 per me G843 5-19-05 tas Certificate of Death			15663
			Decedent's Name (First, Middle, Last)	2. Date of De.		3. Time of Death
	Physic /Medi		SHIRLENA SENORA DAVIS	Month	06, 200	5 15:35 M
	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of De	eath
X			1100 Bolton Avenue Apartment 417 Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	Hrs. 8. Date of Birt	N	
0,0	Funeral Director			Min. (Month, Da	y, Year) 1045	Birthplace (State or Foreign Country)
	pu »		Usual Residence of Decedent			
	the Marylar 28a-f show	ō	10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 ▼Yes 2 → No
	r 28a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
	23a or	aiD	1100 BOLTON STREET #417 21201		USA	,
	Itama Inarmi	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
36	ir, or l	by Funeral Director	1 Never Married 2 Married 1			SLACK
9	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show ha Madical Examinar must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	- / :-	16b. Kind of Busines	
21	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	working	T1 = 0=00.	
d 2	filed v Hygie othar t		12.7H GRADE NA ASSEMBLY L 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle,	ELECTRON	iics
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Department: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahou Introportent: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahou Introportent: if Itema Madical Examinar must be notified at once.	To Be	JOHN TILLERY MARY	WHITE	,	
/an	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
e,	1 and Health am 27 thar t		SENORA A ROBERSON 5111 EVERGREEN FOR 20a. Method of Disposition (Name of	REST WAY	KALLEGH 20c. Location - City	NC 27616
nor	ages ant of ht: If It		1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			
Baltimore,	permit. F Departme Importar any Injur		21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHO C. GREENE			OM, MO
8	8958		15151 BALTO. NATT. PI	IKE BALTO	o.mo 212	29
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heaft failure. List only one cause on each line. Immediate Cause (Final	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) End Stage Renal Disease Due to (or as a consequence of):			
- 60	Examiner	П				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
^	be executed lician and burial-transit	Examiner	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transi	dicai E	d			
		Medi	IF FEMALE:			
Вох	eath certif attending for use as	lan/	23b. Was decedent pregnant in the past 12 menths?		23d. Date of d Month	elivery Day Year
P.O.	the de	nysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			·
S, D	es thal gned t	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ord	requir een si ould i	eted		- 1 Y	es 2 No 3 I	Probably 4 Unknown
Vital Records,	nelaw hasb ge 2 st	Completed		24a. Was a		autopsy findings available completion of cause of
tal	in: Th	ပိ	25. Was case referred to medical 26. Place of F	1 Yes	2 □ No 1 1 1 Y €	es 2 No
Ž	Physicis this cert al direct	To Be	examiner?	Death <i>Check on or</i> g Home 5 ☐ Resid	12	SCENE
Division of	ding Ph h. After th funeral	:uo	27. Manner of Death 1 Avatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		ow injury occurred	
isio	Nttendi death. ctor: A y the fu	licati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm street factors office	28f Location (S	treet and Number or I	Dural Pauta Number
Ο̈́	s after N Dire	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	n, State)	nurai nobie wamber,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funatal Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placed to the company of the basis of examination and/or investigation, in my opinion, death occurred.	ace, and due to the o	ause(s) and manner a	as stated.
	ithin 2, or the formula ithin 2, or the formula ithin 2, or the formula ithin 1, or the formula ithin	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
	F 3 F 8		Mounte Por Monde two OCME		May 07,	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			MARGARIA A KORFU 111 Penn Stre	et Balti	more, Mary	land 21201
	Sta Registi	-	31. Date filed (Month, Day, Year) MAY 1 0 2005			

State of Maryland / Department of Health and Mental Hygiene	n	1	-
Cortificate of Dooth	U	0	9

Medical As Facility Name (if not institution, give street and number) Manor Care Social Security Number 6. Sex 127-30-3265 Usual Residence of Decedent 102 2128 103 2316 104 215	Citizen of What C U.S.A. 14. Race - Am Black, Wh	2:05 P M nore iinthplace (State or Foreign Country) taly 10d. Inside City Limits 1 Yes 2 No Country?			
## April Park Facility Name (If not institution, give street and number) Manor Care	Baltim 9. Big 1915 Citizen of What C U.S.A. 14. Race - Am Black, Wh Specify: W	nore sinthplace (State or Foreign Country) taly 10d. Inside City Limits 1 Yes 2 No Country?			
Director 127-30-3265 1	Citizen of What C U.S.A. 14. Race - Am Black, Wh Specify: W	10d. Inside City Limits 1 Yes 2 No Country?			
Top State Top Catons Top	U.S.A. 14. Race - Am Black, Wh Specify: W	1 □ Yes 2 No			
Nicola D'Antona Nicola	U.S.A. 14. Race - Am Black, Wh Specify: W				
Nicola D'Antona Nicola	Black, Wh	erican Indian			
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23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	өп Ѕитатө)	У			
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	y or Town, State,				
Physician / Medical Examiner 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Less pure unable of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Ense. Underlying cause given as consequence of): Due to (or as a consequence of): Due to (or as		, Maryland			
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Due to (or as a consequence of): Compared to the part of the pa		Approximate Interval Between Gnset and Death			
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1					
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The string of the significant southers significant southers and the second of the seco	23d. Date of de Month	lelivery Day Year			
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E ≡ 5	prior to death?	autopsy findings available o completion of cause of s 2 \square No			
1 Inpatient 2 ER/Outpatient 3 DOA Output 4 Wursing Home 5 Residence		ecify)			
27. Manne of Death 27. Manne of Death	ate)				
29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (and manner stated). 29a. Certifier (Check only one) Certifier (Check one) Certifi	(s) and manner a ind place, and du- Date signed (Mon	ue to the cause(s)			
/ (f no) 9/9/03 00/1569	579105				
30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 0 2005 MAY 1 0 2005	Rel	21208			

			1 - For State Registrar	State of	Maryland /		artment rtificate			and M		giene Reg. No.	005	15665
ı	Physici		Decedent's Name (First, Middle, Brandon	Last) Woodro	ow 1	Duva	11				2. Date of Dea Month May	Day	2005	3. Time of Death 6:24 P M
	/Medic Examir		4a. Fecility Name (If not institution, Frederick Memo	give street and numb	ner)	Juva	4b. City,		Location o	of Death	nay	4c. C	County of Death	
	Funeral Director		5. Social Security Number 212-14-5317 Usual Residence of Decedent	6. Sex 7. 1 X M 2 □ F	Age (In yrs. last I	hirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day March	Year) 4,19	9. Birth Cou 13 Mary	place (State or Foreign ntry) 11and
	ehow		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	tha Ma 28a-f e	Director	Maryland Montg	omery	Dan	nasci								1 ☐ Yes 2X No
	3a or			_			10f. Zip		070			-	on of What Cou	ntry?
336	be filed within 72 hours after death with tha Maryland lal Hygiene. Id other than "naturel", or tlems 23a or 28a-f ehow event, tra Marical Ever il arr and the rediffed at	by Funeral	25511 Oak Driv 11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force	es? XNo		Was Decedor Yes, special	ent of Hi rfy Cuba	872 spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	14	S.A. Race - Ameri Black, White,	etc.
21215-0036	ithin 72 hou se. nan "nature Mexical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			(Give life.	dent's Usual kind of worl DO NOT use	k done d e retired,	luring most)	t of workii	9		of Business/Ir	dustry
d 21	should be filed withir and Mental Hygiene. Ie marked other than aumatic event, Item	Be Cor	12 17. Father's Name (First, Middle, L	ast)		Po.	lice ()III		r's Name	(First, Middle,		Troop	
Maryland	d 2 should be the and Mental by 7 le marked of traumatic ever	ToB	Sherwood Duv								R. Fu			
	12 mg		19a. Informant's Name/Relationshi Louise B. Duval		15						<i>Route Numbe</i> scus, M			872
Baltimore,	t H H H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spi	3 □Removal from Sta		of Dispo	sition (Nam natory or oti	e of her place	9)	D	ate	20c. Loca	ation - City or To	own, State
Balti	permit. Page Department of Importent: If any injury or office.		21. Sign ture of Fineral Service Li	cences (.//:)	0.22	Metho Name and Lin L.	Addres Mo.	s of Facility	rth	ry 5/11 P.A., F	unera	al Home	
	i		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cau nly one cause on eac	sed the death. Do	not ent	er the mode	cidge of dying	e Roa g, such as	d , D	amascus r respiratory arr	• Mai	ryland	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or	as a consequence	S e of):	-							LYhr
	Examiner	Examiner	Sequentially list conditions, I ary, teating to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	URIWAN as a consequency	2y 7	RACT	I,	NFE	CTU	n	_		12hr
,0928	cate be executed physician and s the burial-transit	dical	resulting in death) Last	Due to (or	as a consequence	e of):								
.O. Box 6	the death certify the attending iched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 □ Fetal deat t at time of death		Ectopic pre Other (spe					230	d. Date of delive Month	ery Day Year
<u>α</u>	signad b	by	Part II. Other significant condition DINIETS: Me			in the ur	nderlying ca	use give	n in Part I.		23e. Did tol			ne cause of death?
al Records,	The law ate has b page 2 sl	Completed	MORBINON	BESMY						_	24a. Was a autops perform	У	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of
Vital	Physicien: this certificar al director, p	o Be	25. Was case referred to fiedical examiner?	Hospital:				Othe	-		Check onl on			
ion of	ding After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga			Time of Injury		c. Injury Work	at Nur	2	ie 5 ☐ Reside 8d. Describe ho			v)
Division	or Direction	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 280. Place of	Injury - At home, i etc. (Specify)	farm, stre	eet, factory,	office		2	8f. Location (St City or Town	reet and f n, State)	Number or Rura	l Route Number,
	he Hospital on 24 hours at he Funerel Dipletely filled in	Medicai	29a. Certifier 1 Certifying (Check only one)	Physicien: To the be ceminer: On the basis and manner	s of examination a	ge, death nd/or inv	occurred at estigation, i	t the time	e, date and inion, deat	l place, a	nd due to the ca d at the time, d	ause(s) ar ate and pl	nd manner as st ace, and due to	ated. the cause(s)
}		Σ	29b. Signature and title of certifier	P. ful:	MD				number	191			igned (Month,	
	13	1	30. Name and address of person w	no completed cause of	of death (Item 23a)	(Type, I	Print)	Tilain	0-1	Da	10 750-	، د المسرور	1100	021702
	Sta Registr	100	31. Date filed (Month, Day, Year) MAY 1 0 2005		strar's Signature	110M)	UNIV	I MUL	114	it FRE	12 je je j	ue jus	12/102

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 2005 ThA /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ANOR C Son If Under 24 Hrs. OW TIMOR Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday **Funeral** Months Days 1 M 2 F Hours 215-46-Yrs. 6608 14, 192 Director MAR. AROLINA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits # show r 28a-f show 1 DYes 2 □ No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Mudical Exerning Paral be 2115 21 4 death Funeral d 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 12 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: BIACK If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ULANE other than Elementary/Secondary (0-12) College (1-4or 5+) EDICINE HOME Department of Health and Mental Hyg Importent: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental YIJAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA 2010 MASSEY 20b. Place of Disposition (Name of cemetery, crematory or other place Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) RDutus 5/1 2005 21. Signature of Funeral Service Licensee nES, permit. un, Sve. once BROADWAY sour 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death mode of dying, such as cardiac sepiratory Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the phys attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 4 Unknown 3 Probably 1 Tyes 2 No certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 29 No Division of Vital 1 Yes To the Hospital or Attending Physician: Atter this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: 1 Inpatient 2 No Other: 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5W 500 w Zas 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:06 PM 2005 James Kevin Durkin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES HEALTH CARE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUN 4, 195 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1- M 2 □ F 7. Age (In yrs. last birthday) Funeral Months Hours 218-68-1065 Director Texas Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show Yos 2 □ No Be Completed by Funeral Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5229 Hillwell Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status the Medical Examinar Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Equipment Specialist U.S. Coast Guard Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If itam 27 is marked othar t jury or other traumatic evant, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Durkin, Sr. Lorine McDougall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Smith/nephew 707 Trail One Burlington, NC 27215 20a. Method of Disposition 1 □ Buriał 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Depentment Important: If any injury of once Metro Crematory, Inc. 5/9/05 Baltimore, MD ' 4 Donation 5 Dother (Specify) 21. Signature of uneral Service dicensee Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATO-RENAL SYNDROME clays /Medical Due to (or as a consequence of) **Examiner** HEPATIC CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed 2 No 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral 28b. Time of Injury 27. Manner of Death Medical Certification:

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Thomicide

5 Pending investigation

6 Could not be

determined

29c. License number 1+602 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, SOOCATON AVENUE, BALTIMORE, MARYLAND 21229 KHINTKIEWICZ

Registrar

2. Registrar's Signature

within 24 hours a To the Funeral C

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 3 **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bult Baltimore MO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1X M 2□ F Months Hours 79 SC Director 251-62-1019 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State itam 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic event, it a Medical Examinat must be nutified at tX Yes 2 ☐ No Director BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2329 EDMONDSON AVENUE 21223 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MASH'S HAM CO. 8 MEAT PACKER s 1 and 2 should be filed with Health and Mental Hygier item 27 Is marked othar them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LETTIE COCKFIELD EDWARD DICKERSON, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2329 EDMONDSON AVE. BALTIMORE, MARYLAND 21223 JUANITA DICKERSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permil. Pages
Department of I
Important: If it
any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-14-2005 BALTIMORE, MARYLAND CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ke of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between nset agd Death Immediate Cause (Final **Physician** in leven disease or condition resulting in death) /Medical Due to (or as a consequence of): trap renal disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

Will heller utto. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐Unknown 1 Yes 2 should Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: Other: 4 Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled Hospital ᡝ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month Day, Year) 29b. Signature and title of certif 2 79/03 who completed callse of death (Item 23a) (Type, Print) 30. Name and address of person 21208 Temus

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 0 2005

Registrar's Signature

		•	For State Registrar	State of Marylar	-	ment of He			ene 005	15669
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	DINA	KEL	15		2. Date of Death Month	G Zooj	0300 M
	Examin	er		OSPITAL			ALLSTO If Under 24 Hrs.		4c. County of Dee	MORE
	Funeral Director		5. Social Security Number 218-25-2720 Usual Residence of Decedent	IM 2□ F 77		Months Days	Hours Min.	8. Date of Birth (Month, Day, 02/04/19	928 C	thplace (State or Foreign ountry) UKRAINE
	Maryland I-f show	tor	10a. State 10b. County MD BALTIMORI		ty, Town or Local	tion				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23e or 28a	al Director	10e. Street and Number 49 PENNY LANE			10f. Zip Code 21209		10	og. Citizen of What C	ountry?
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other traumatic event, the Madical Examination in the fired at the filed at 1.8.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		s Decedent of His es, specify Cubar Yes 2 🕅 No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: WH	te, etc.
21215-0036	filed within 72 ho Hygiene. Ather than "nature int, the Medical	ompieted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give kir	NOT use retired)	uring most of workir	ng	LIGHT IND	·
Maryland 2	2 should be filed and Mental Hyg is marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last) MORDECHAI		DINKE		18. Mother's Name			INKELIS
	1 and 2 sho Health and h em 27 is me		19a. Informant's Name/Relationship (Ty IGOR DINKELIS / S	ON	49 PE	NNY LANE	BALTIMO	RE, MD		
Baltimore,	permit. Pages 1 and . Department of Health important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 🛣 Buriai 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	amousi from State		non (Name of tory or other place NO CONG.	05/09/	′2005 B	ALTIMORE,	MD
Balti	permit. Departnimports any injit		21. Signature of Funeral Service leicens	Kul		Name and Addres			SON & BROS PIKESVILLE	, MD 21208
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line. a. Due to (or as a conse	PNEU	the mode of dying		r respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner points	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease of Figure 1 that initiated events	Due to (or as a conse	quence of):					
68760,	tificate be executed ig physician and as the burial-transit	cai	resulting in death) Last	Due to (or as a conse	quence of):					
.O. Box	death cer e attendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 S No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	el death 3 □E	ctopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Δ.	sign d be	by	Part II. Other significant conditions co.	ntributing to death but not re	sulting in the und	erlying cause give	en in Part I.		pacco use contribute es 2 □ No 3 □ F	to the cause of death? Probably Nknown
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was a autops perform	v prior to	
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 Popatient 2	☐ ER/Outpatient	3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor		a) ence 6 □Other (Sp	ecify)
Division of	ding After fune	ation: T	27. Manner of veath 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury Work M 1 🗆 Y	/ at { k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	or At ofter d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stree ify)	et, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	e Hospital 24 hours a e Funerel I etely filled	ledical	29a. Certifier (Check only one) 185 Certifying Phy	sician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, death of nation and/or inve	occurred at the time stigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, d	ause(s) and manner a ate and place, and du	is stated. se to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	en le	7	29c. License	7733		9d. Date signed (Mor	Toos
-	1		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type, P		. MO:			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		arte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2005 Year April 16, **Physician** Fisher 1:45 am M Gladys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring

| Houser | Spring | State of Birth | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | St Center Montgomery Fox Chase Rehabilitation & Nursing 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 X F 228-30-4465 84 Baltimore MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. At the state of 28e-1 show item 27 is marked other than "natural", or liems 23a or 28e-1 show other treumatic event, Ite Marical Examine in other treumatic event, Ite Marical Examine in 1∏Yes 2 □ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 East/West Highway United States 20910 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: Specify: **Black** 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eighth Federal Government Mess Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should b Iment of Health and Ments tant: If item 27 Is marked James W. Carr Pauline Caul ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Missouri Avenue NW #1, Washington DC 20011 Carolyn Crittendon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) April 21, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) Landover Maryland 2005 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Road SE, Wash DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Possible Acute Myocardial Infarction /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death should be detached the 9☐ Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificete 2 🗆 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ANursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? Attending 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death unerel Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 filled Hospitel 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0058597 April 16, 2005 30. Name and address of person who completed Shahryar Davari, M.D. cause of death (Item 23a) (Type, Print)
8609 2nd Avenue Suite 404B, Silver Spring MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 0 2005 Registrar

amend item#18, perFit, C843, 5/10/05 TT State of Maryland / Department of Health and Mental Hygiene 0 5 For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:30AM Christine Frasca May 5 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner Baltimore 118 Gibbons Blvd. Cockeysville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number TRABCA CLINATING **Funeral** 1□M 2□F 81 May 3, Director 216-14-7882 Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or itams 23a 118 Gibbons Blvd. 21030 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 2 No white Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ex Pietro Parenti Nancy Minolti Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 Gibbons Blvd., Cockeysville, MD 21030 Gene Frasca/Son 05/07/2005 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 21093 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael J. **Report** 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ena muth **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) attending physicien P.O. Box 68760 as the IF FEMALE: use If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day for 4 Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 Yes 2) or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 20 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Defectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and Jiff of certifier MO 305 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Celano, M.D. 6569 N. Charles St. Suite 205 Towson, MD 21204 31. Date filed (Month, Day, Year) State Registrar 2005 0

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5672 State of Maryland / Department of Health and Mental Hygiene 🛭 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:34 AM F07 ILLIAM 2005 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SECOUR HOSPITAL BACTIMORE
If Under 1 Year If Under 24 Hrs. BON N/A 8. Date of Birth (Month, Day, Year) 11-1-1917 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ F NORTH CAROLINA 216-03-9892 87 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts 77 is marked other than "natural", or Itams 23a or 28a-f show treumatic event, the Medical Examinar transities notified at 1 XYes 2 No Director N/A BALTIMORE MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2812 WINCHESTER ST. USA filed within 72 hours after death Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐XWidowed 4 ☐ Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FORKLIFT OPERATOR HARBESON WALKER REFACT -12--0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumstic event 2008. Be MATTIE CHESSON WILLIAM A. FOY, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. FOY III(SON) 1600 CHESAPEAKE AVE. BALTIMORE, MARYLAND 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Fremayon 3 Removal from State

Some (Specify) ENTOMBMENT ARBUTUS MEMORIAL PARK 5-10-2005 BALTIMORE, MARYLAND 1 Burial 2 T ^¹ 4 □ Donation SeeJONATHAN D, HIBNER Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, we heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONCESTIVE Failure Immediate Cause (Final disease or condition HEART Physician resulting in death) /Medical Due to (or as a consequence of) Failure Examiner denal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner HTHERO Sclerusis The law requires that the death certificate be executed the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760. resulting in death) Last Due to (or as a consequence of); Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERT ORONARY Disease 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 2 🕡 No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1€Inpatient 2□ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R.M SLOL H) D19668 Hospital Balhmore me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secons R.M. SHAH MO Bon 31. Date filed (Month, Day, Year) 1 0 32. Registrar's Signature State 2005

Registrar

Kevin Lee Flynn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03204 For Unpend Item 23a,27,28a f per me 6844 6-8-05 tas Reg. No. RPD 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 8, 2005 **Physician** Year Kevin Lee Flynn 0503 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 137 Back River Neck Road Essex Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 218-84-5034 Yrs. June 25,1970 Director 34 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 7929 Main Street 21226 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4X Divorced "naturet", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic event, the Madical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roofer 8 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of William McNeil Cheryl Darlene 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 7929 Main Street, Curtis Bay, Maryland 21226 Cheryl Riley (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory May 10,2005 Baltimore, Maryland Signature of Euneral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Maryland 21221 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Methadone intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ 28a. Date of Injury Found, Day Year) 5-8-05 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Found 4:55 1 Natural 5 Pending investigation 1 ☐ Yes 2 ₹ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number Back River Neck 4 T Homicide

Hospital or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Certification: Director: d in by the To the Hospital within 24 hours a To the Funerel C 29a. Certifier Medical 29b. Signature and title of certifier

Scene Road, Essex, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number OCME May 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Soughall, MD 111 Penn Street Baltimore, Maryland 21201

State Registrar

legistrar's Signature 31. Date filed (Month, Day, Year)

MAY 1 0 2005

			For State Registrar	State of Ma	ryland /		rtment of			nd M	ental Hy	/gien	600	5	158	74
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	3. Gr	ady						2. Date of Do Month 05 · 05	. 20	05		3. Time of E	Death A M
	Examin	er	4a. Facility Name (If not institution, give s 3410 COTWOOD PL	ACE			46. City, Town			Death		44	c. County of D	Path		
	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	7. Age	(In yrs. last b	virthday) Yrs.	If Under 1 Ye Months Da	ear	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	rth ay Xear		Birthplac	ce (State or	Foreign
	72 hours after death with the Maryland 'natural', or Items 23e or 28e-f show dical Exacilier must be notified at	_	10a. State 10b. County		10c. City, To									10d	I. Inside City	
	the Mark	Director	MD NA		BALTIN	NORE	10f. Zip Cod	de				10g. C	itizen of What	Country	1 ⊠ Yes : 	2 No
	ath with		3410 COTWOOD PLA	CE			212						USA			
ပ္	after de or Items officer n	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N		lf lf	Vas Decedent of Yes, specify C	Cuban	, Mexican,	in? (Spe Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W	hite, etc	c.	
-003	hours a	ed by	3 ☐ Widowed 4 M Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:	16		Yes 2 1		Specify:			105	Specify: B			
21215-0036	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+) _	(Give I life. E	ent's Usual Oc kind of work do OO NOT use rei	ne du tired)	ring most				Kind of Busine			
	filed with Hygien other the ent. Its	e Con	12 TH GRADE 17. Father's Name (First, Middle, Last)	2 YRS.		AY	CARE		STRU 18. Mother		(First, Middle		ITIMOR n Sumame)	E	CITY	
Maryland	should be nd Mental marked c	ToB	WILLIE GRADY					1	ALTHA	AUS	NORK	1001)			
	d2 tha 7 is		19a. Informant's Name/Relationship (Ty) REGINALD GRESH		. \		g Address <i>(Str</i> e WESTHI					-	or Town, State	e, Zip C	ode)	
ore,	Pages 1 a nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place cemet	of Dispos ery, crem	sition (Name of atory or other	f		Di	ate	20c. L	ocation - City		n, State	
Baltimore,	it. Parturant		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	90	DRUID	4	GE Name and Ad AUGHN (ldress		5.13.			ESVILLE		10	
ä	Depa Depa Impo any i		1 / Aughn C-	Coveene	2	3	151	Ri	DIT	0 V	INTL	. 4	SERVICE	2	1270	
	Prrysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	bote	i (elin the mode of a	dying,		ardiac or		irrest,		A In O	pproximate Iterval Betweenset and De	eath
Ü	Examiner		Sequentially list conditions,	Due to (or as a	consequence	e or):										
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):								1		
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9	tificate ng physi as the l	fedicai	d											1		
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Ω.	sign sign d be	ed by Pł	Part II. Other significant conditions con	tributing to death bu	t not resulting	in the un	derlying cause	given	in Part I.			tobacco Yes 2	use contribute		cause of dea	
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	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	ospital: 1 Inpatier	t 2 ER/O	utpatient	3□ DOA	Other			(Check only	/	6 □Other (S	necify)		
o uc	ling Phys 1. After this tuneral dia		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. lr	Work?	at	2	8d. Describe			Journey		
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۵	pital or A burs after leral Direc filled in by		29a. Certifying Phys						data and	place of			· 			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Examir one)	er: On the basis of and manner stat	examination a	nd/or inv	estigation, in m	ny opir	nion, death	occurre	d at the time,	date an	d place, and d	ue to th	e cause(s)	
}		Z	29b. Signature and title of certifier		MD		1)4	71	number 76	^		5	ate signed (Mo	OT	_	
-			30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, F	Print) Ka	V	cu I	310	1,1	Bal	L. M	(J	212	39
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra		1										
DH	MH 17 Rev 1/20		MAY 1 0 2005	Marie	A A	S. See of										

ORIGINAL

Datient twown as Walcolm Gaskins

Baltimore, Maryland 21215-0036

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		1	State Registrar			Cert	ificate d	of Death		Reg. No	2005	15675
Phys	iaia		1. Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Da	y Year	3. Time of Death
	dica	1	MALCOLM OWEN	GASKINS	3				MAY	7		23 34 M
Exar	nine	r	4a. Facility Name (If not institution, give s				_	n, or Location of Deal	h	40	: County of Dea	
Funor	lo.		5. Social Security Number 6. Sex			last birthday)	Baltin If Under 1 Ye			irth	N 9. Bir	thplace (State or Foreign
Funer Direct				-	48	Yrs.	Months Da	ys Hours Min.	05 09	av. Year	C	MD
pu ×			Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	tion					10d. Inside City Limits
Aaryla f sho		อ	MD NA		_	MMORE						1 LYes 2 No
the rate		ect	10e. Street and Number		UHL	IIIIOKE	10f. Zip Cod	le		10g. Ci	tizen of What Co	ountry?
h with		2	3106 MONDAWMII	J AVENI	JE		212	ماا			USA	
r deat		Funeral Director		12. Was Decedent E Armed Forces?		.S. 13. W	as Decedent Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or N to Rican, etc.)	10-	14. Race - Ame Black, Whi	
If it is in the Maryland filed within the Maryland Hygiene. Hygiene. Softer then "natural; or items 23a or 28a-f show on the Maryland in the Maryland in the Maryland is in the Maryland in the Maryland is in the Maryland in the Maryland in the Maryland is in the Maryland in the Maryland in the Maryland is in the Maryland in the Mar		by FL	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 KNo If Yes, Give Year or Dates:)	1	∃Yes 2⊠				Specify: Q	AAV
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filed with Hygiene.		50	12/11 GRADE	NA		ASSE	MBLY				CORMIC	CKS
Id be fill fental H rked off		Be	17. Father's Name (First, Middle, Last)	10					me (First, Middle		n Sumame)	
MICE IN THE CONTROL OF THE CONTROL OF THE MANY OF A Should be filed within 72 hours after death with the Marylar th and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show traumate event, the Medical Examinations to inclined at		0	JOHN GASKINS , 19a. Informant's Name/Relationship (Ty	pe. Print)		19b Mailing	Address /Str	MAXINE eet and Number or R			or Town State	Zin Code)
nd 2 s with ar 27 is			MAXINE GASKINS	/ -	er)	_		AWMIN A				•
es 1 an of Heal fitem 2			20a. Method of Disposition		20b. F	Place of Disposi cemetery, cremi	tion <i>(Name o</i> .	place)	Date	20c. L	ocation - City or	Town, State
rmit. Pages partment of portant: If it y injury or or			1 M Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ARI	BUTUS		05.	4.05	BAL	TIMORE	mp
Datullore, permit. Pages 1 a Department of Hez Important: If item any injury or othe	Suce.		21. Signature of Funeral Service License	* Y		VAL	Name and Ad	dress of Facility GREENS NATL PI	FUNER	AL S	SERVICE	220
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/Medic	al		disease or condition resulting in death)	Due to (or as a			10	1030127				(week
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w requires been sign should be		ed by	Seizure disor	del					1 🗆	Yes 2		robably 4 Unknown
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The The ate h		Com							per 1 ☐ Yes	opsy formed? 2 K No	death?	completion of cause of s 2 No
ysician: Thysician: The is certificate director, pag		Be (25. Was case referred to medical examiner?	(asabal)					ath (Check only			
shys this		2	1√ Yes 2 No 1 27. Manner of Death	fospital: 1 Inpatier		ER/Outpatient 28b. Time of		Other: 4 Nursing	Home 5 Res			ecify)
nding Phy th. :: After thi		ation:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury		Work? 1 □ Yes 2 □ No			.,	
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To the within 2 To the complex		Mec	29b. Signature and title of certifier	and mainer stat			29c. Lic	ense number		29d. Da	ate signed (Mon	th, Day, Year)
F > F 0		_	1 lyn	m.	<i>. C</i>			RES-00	D	V	MAY &	7,2005
11			30. Name and address of person who co		ath (Iter		rint)			- 10		
0,	Carr		11NG WEI LUW 31. Date filed (Month, Day Year)				HOSPITA	L OF 13	ALTIMO	ISE	0	
1 20	Stat istra		31. Date filed (Month, Pay, Year) MAY 1 0 20	332 Registra	e A	& Gos	de					

			State of Maryl	and / Den			Apptal Hyair	•	
			1 - State Registrar		ertificate of			2005	15677
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
П	Physici /Medic		DONALD BRADFORD GULL	EDGE			Month May	Day Year 2 200.	1047 AM
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Dea	
	71		4 WINSAPCOURT-APT	T'		SVILLE		BALGIA	
	Funeral Director		5. Social Security Number 6. Sex 1/2 M 2 F 6	yrs. last birthday O Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 28,	(ear) 9. Bir	thplace (State or Foreign
	σ		Usual Residence of Decedent	0			July 20,	1944 Mai	yland
	anylan show	_		. City, Town or L					10d. Inside City Limits
	he M	Directo	Maryland Baltimore	Catons					1 ☐ Yes 2X No
	Sa or				10f. Zip Code		100	g. Citizen of What Co	ountry?
	death ms 23	Funeral	4 Winesap Court 11. Marital Status 12. Was Decedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	U.S.A.	erican Indian,
ထ္	or ite	Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ X Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show that the Macical Examinat coust be mailled at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						nite
ည်	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work	ting 16	6b. Kind of Business	Industry
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g	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show avent. Its Misciell Emidian oust be nuffiled at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma		
<u> </u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ihu M.	To	Edward C. Gulledge			Elizabe	th C. Bra	dford	
Maryland			19a. Informant's Name/Relationship (Type, Print) Lucille Gulledge (Wife)					City or Town, State, .	
	ges 1 and t of Health if item 27 or other tr				osition (Name of ematory or other place			Maryland C. Location - City or	
ē	Pages nent of I ant: If its ury or o		Total 2 Cleritation 3 Emandoval notificate		ematory or other place n Nationa	i i		rlington,	
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			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.			,			Approximate Interval Between
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0	that the de led by the a detached t	Phys	9 Unknown						
ŝ	res thai signed to be det		Part II. Other significant conditions contributing to death but not	-					o the cause of death?
Š	w require been si should t	eted	HISTORY OF COLONCANCS	2	- su on hy	St40			
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Vital		a	25. Was case referred to medical			26 Place of Deat	1 ☐ Yes 2 ☐	ZNo 1 ☐ Yes	2 No
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0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Yea	28b. Time o	of 28c. Injun World		28d. Describe how		
8	Attending r dt ath. sctor: After by the fune	cati	2 Accident investigation	411		Yes 2 □ No	006 1 10		
Division of	i Sign	Certification:	4 Homicide determined 28e. Place of Injury - 4 building, etc. (Sp	at nome, tarm, st secify)	treet, factory, office		City or Town,	et and Number or Ru State)	ıral Houte Number,
	spita hours ineral y fillec		29a. Certifier 1 ☐ Sertifying Physician: To the best of my	knowledge, dea	th occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or ir			red at the time, date	e and place, and due	to the cause(s)
	With To	Σ	29b. Signature and title of certifier	11.5	29c. Licens	e number	290	f. Date signed (Mont	h, Day, Year)
	∕i		6 to le le consonation	MD,	D/	1171	m	142,20	05
6	1		30. Name and address of person who completed cause of death	μιθπ 23a) (Type	, Printi	ELL .	A 14	naukan	2 11042-
ľ	∌ Sta		31. Date filed (Month, Day, Year) 32. Registrar S	ignature			10111	7 700	
ŀ	Registr	ar	MINI TO SOUR DE	sever so	1 Sperke				

Physicia		1. Decedent's Name	(First, Middle			GAI		J.J.		2.	Date of Death Month 05	Day 07	2005	3. Time of Death
/Medic	al .	4a. Facility Name (If I	CK not institution			0 17		Town or	Location of	0	5 08 20			9:15 A M
Examin	er	6400 Oak		_	mber)							_		
Funeral Director		5. Social Security Nu. 220–36–35	mber	6. Sex 1 ⊘ M 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	rg If Under 2 Hours	4 Hrs 9. Min. 9	Date of Birth (Month Day) 3 1 1 C		place (State or Foreign Tand
put k		Usual Residence of D	Decedent 10b. County		10c City	, Town or Lo	eation			0.	3-15-15	39		10d. Inside City Limits
with the Marylan s or 28a-f show the nutified at	to	Md	Carro	11		ersbur								1 ☐ Yes 2 No
th the Mi or 28a-f	Director	10e. Street and Num	ber				10f. Zip	Code			10	g. Citizen of V	What Cour	ntry?
s 23a		6400 Oak	Hill				217					U.S.A.		
36 atter death v or Items 23a	Funerai	11. Marital Status 1 Never Marrie	d 2 Mari	Armed/Fo	edent Ever in U.9 prces? 2 ☐ No					in? (Specify Puerto Rica	Yes or No- an, etc.)	Blad	k, White,	
21215-0036 d within 72 hours after death with the Maryland glene. glene. If w Medical Examinational be multiled at	þ	3 Widowed 4		Year or D	ve lates:		1☐Yes 2	No	Specify:			Specify	Whi	te
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trade file	Be	17. Father's Name (F	irst, Middle,	Last)					18. Mother	s Name (F	irst, Middle, M	laiden Suman	10)	
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Ma nd 2 s uith ar 127 is r trau		Mrs. Ange							Drive					d 21784
Baltimore, Moemit. Pages 1 and 2 permit. Pages 1 and 2 pertment of Health mportant: It item 27 inny injury or other trans.		20a. Method of Dispo	siţion	3 □Removal from		lace of Dispo emetery, crei	sition (Nan	ne of	- 1 -	Date	-	0c. Location -		
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Baltin permit. P Departm Importar any injun		21. Signature of Fun	ecul Service	Licensee										irectors In
EURI		23a. Part1. Enter the	disease, or	only one cause on e	caused the death							- T	mary.	Land 21133 Approximate
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. /Medical Examiner		resulting in death)		Due to	(or as a consequ	uence of):	Rena	1	100	/				4125
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cuted cuted	Examiner	that initiated events	njury	С			ldy	bul	indo	n-			- 11	year
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Box 68 leath certitica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent			tcome of pregnar		⊒Ectopic pr					23d. Dat	te of delive	эгу
O. B le deat the att	sicia	in the past 12 n 1 Tes 2			nant at time of de		Other (sp					Мо	nth	Day Year
S, P.O. es that the d gned by the be detached		Part II. Other signific	ant conditie	ons contributing to d	eath but not resu	ulting in the u	indertying c	ause give	n in Part I.		23e. Did tob	acco use cont	ribute to th	he cause of death?
rds, quires on sign uld be	ed by										1 ☐ Ye	s 2 □ No	3 🗆 Prob	pably 4 Onknown
Record le law require has been si ge 2 should l	Completed										24a. Was an	24b. \	Were auto	psy findings available mpletion of cause of
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	Ĕ	27. Manner of Death		28a. Date	Inpatient 2 I of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 LI NUIS			v injury occur		у)
of Vital Records, g Physician: The law requirest there this certificate has been signe neral director, page 2 should be contained.	<u>-</u>	a EDA L	5 Pendir		an, bay roar,	injury	М		res 2□N	0				
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Division of Vital Records, P.O. Box 68760, within 24 burs alter death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Attentia the certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	cai	2 Accident 3 Suicide 4 Homicide	investi 6 Could determ	not be inned 28e. Place build	best of my know	wledge, deat	h occurred	at the tim	بالاحجاب بمحاجات	place, and	City or Town,	State) use(s) and ma	nner as s	tated.
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	-	artment of H			jiene leg. No.	05	15679	
	Physici		1. Decedent's Name (First, Middle, Last) MARY (ASIX)					2. Date of Dea Month MAY	Day	Year	3. Time of Death	
	/Medic Examir		17.1. 03 2003)							0.0		
Ī	Funeral Director		5. Social Security Number 218-26-7090 6. Security Number 1 C	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. Octo	8. Date of Birth (Month, Day Der 11,	, Year)	9. Birthp Coun Virg	place (State or Foreign http) inia	
	ow at		10a. State 10b. County	10c. C	City, Town or Le	ocation				1	0d. Inside City Limits	
	ith the Marylar or 28a-f show	ctor	Maryland Baltimor	e P	ikesvil	le.					1 ☐ Yes 2 🛣 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen o	of What Coun	ntry?	
980	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28a-f show or other treumatic event, the Marical Examinar must be invitted at	rai	4717 Duncannod Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec							d Stat		
		by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Privorced	Armed Forces? I		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:			14. Race - American Indian, Black, White, etc. African— Specify: Americian			
5-0	72 h	Be Completed by Funeral	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo:				during most of worki	ng		b. Kind of Business/Industry		
21215-0036	12 should be filed within 7 and Mental Hygiene. Tis marked other then "reumatic event, the Med		Elementary/Secondary (0-12)	College (1-4or 5+) 5+						ltimore City blic Schools		
nd	al Hyg al other		17. Father's Name (First, Middle, Last)				18. Mother's Name			.,		
Maryland	Ment Ment Markec Maric e	Tol		Gaskins	11			Florence		inson		
Mar	id 2 sh lith and 27 Is m treum		19a. Informant's Name/Relationship (Ty Leslie Miscevic				and Number or Rura non Road,					
ore,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ee)	ate	20c. Locatio	n - City or To	wn, State	
Ĕ	Pages ment of I ant: If its ury or o		1 Burial 2 Cremation 3	Arbu			rk May 1	E		-	•	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tru QDC9.		21. Signature of Funeral Service Lidense Joseph D. C.	ena Moojj	0.		ss of Facility Lor ty Rd., R				irectors,II 3-4784	
U			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death								Onset and Death	
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
	ecuter and I-trans	xam										
8760,	cate be executed oblysician and the burial-transit	dical E										
9	rtificate ng phys as the	0.										
Вох	To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					23d. Date of Month		Date of delive	delivery Day Year	
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Δ,										e cause of death?		
ords		Completed by	HYPERTENSIVE ATHEROSCIEROTIC CARDIOVASCULAR DISEASE						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vnknówn			
Records,			RENAL FAILURE.					24a. Was a autops	psy prior to completion of cause of			
alF			0.5						2 ZNo	death? 1 🗌 Yes	2 No	
Vital		o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \times No	lospital: 1 Dopationt 2	☐ ER/Outpatier	nt 3 DQA Othe	26. Place of Death		100	Whos /Caraif	a	
n of		T :uc	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 Accident (Noth, Day Year) 3 Accident (Noth) (Not)					ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Division		icati						194 Leasting (C	Continue (Charles and Alice Inc.)			
Div		Certification:	4 Homicide determined						Houte Number,			
		Medicai C									ated. the cause(s)	
	To the To the comp	Ň	29b. Signature and title of certifier			29c. License	number 123		9d. Date sign	ned (Month, L	Day, Year) 2005°	
	1		Hann				and the second second					
	V		A V V ERAHALLI	mpleted cause of death (Ite	em 23a) (Type,	SLOI	UPD 1	Court	ROAD	ا لما 1903 ك		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 0 2	32. Registrar's Sign	nature							

Timothy Grimm 05-03195

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#5, perFH, Inf. C844, 6/16/05 TT State of Maryland 7 Department of Health and Mental Hygiene Unpend Item 23a, 27, 28a-f per me C842 to Death Reg. No.	And the second second
trar Certificate of Death Reg. No.	

			1- For Unpend Item 2	3a,27,28a-	f per me	Rifficate of	\bar{D}_{ath}^{ealth}	Mental Hy	giene () (Reg. No.	15	15680	
	Physicia	an	1. Decedent's Name (First, Middle, Las	2. Date o					3. Time of Death			
	/Medic		Timothy J. Grim	May 8			2005 10:50		10:50 a [™]			
de.	Examir	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
5	2956 Keswick Road 5. Social Security Humber 6. Sex 7. Age (In yrs. last birthday)				Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of B			N/A				
	Funeral Director			xM 2□F 3		Months Days	Days Hours Min. Nov. 3,			y, Year) 1973 9. Birthplace (State or Foreign Country) Maryland		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show airly injury or other traumatic event, the Medical Examinar must be notified at anone.	ctor	10a. State 10b. County	1	Oc. City, Town or Lo					10	Od. Inside City Limits	
			Maryland N/A Baltimore						XXYes 2□No			
		I Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2041 Druid Park Drive 21211 USA							ry?		
		Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. V Armed Forces?		Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric		Specify Yes or No		14. Race - American Indian, Black, White, etc.		
21215-0036	ours after ali, or its Eramina	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2√∑No If Yes, Give Year or Dates:		1 ☐ Yes १ √ No	Specify:	to moan, etc.,	Specify			
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121	vithin ne. han	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Consonate of working life. DO NOT use retired)									
2	filed with Hygiene other than		11 17. Father's Name (First, Middle, Last)		Car	penter	18. Mother's Na	me (First, Middle,	Indepo		t	
an	d be ental ked o	To Be					_	Jean DuBois				
Maryland	2 should be and Mental Is marked c		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street				State, Zip	Code)	
	and 2 lealth a m 27 Is		Jean Grim	Mother		2041 Drui					yland 21211	
J.C.	es 1 a of He itam roth		20a. Method of Disposition	Romaval from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date	20c. Location -			
<u>Ĕ</u>	Pages ment of I ant: If its ury or o		1 万月urial 2 □ Cremation 3 □ 1 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 1 2 □ Cremation 3 □ 1 2 □ Cremation 3 □ 1 2 □ Cremation 3 □ 1 2 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 3 □ Cremation 3 □ 1 4 □ Cremation 3 □ 1 5 □ Cremation 3 □ 1					11,2005	Baltimo	ore Ma	arvland	
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	Physician /Medical Examiner		23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3631 Falls Road, Baltimore, Maryland Approximate Interval Between									
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cocaine And Fentanyl Intoxication									
			resulting in death) Due to (or as a consequence of):									
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	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
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	ntifica ng ph		IF FEMALE:									
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ords,	w requires been sign should be	ted by						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dunknown				
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of \	× .0 0	²	Xies ZIIIO	Hospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury 28b. Time		ent 3 DOA Dthen: 4 Nursing H		Home 5 Residence 6 Other (Specify) scene			scene	
	or Attanding fler death. Diractor: After in by the fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Year) Tolping Work?		28d. Describe how injury occurred unk						
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ā			4 - Nottilcine			Baltimore, Md						
	To tha Hospital or within 24 hours after To tha Funaral Dir. completely filled in In	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							ted. he cause(s)		
	with To t	Σ	29b. Signature and title of certifier			29c. Licens	e number ME		29d. Date signed	(Month, D	ay, Year)	
			, Chiefz	'			J. 111	N	1ay 9, 2	005		
_			30. Name and address of person who of AVA RVA		th (Item 23a) (Type,	111 Penr	Street	Baltimo	ore, Mar	yland	21201	
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar MAY 1 0 2005												
	3.01		MAY 1 0 200	J. Salar Carlot	The same of the sa	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 5681 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 UNTHER MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A ursing (enter timore [-11zabeth a Year If Under 24 Hrs. 8. Date of Birth Nov. 22, 1913 7. Age (In yrs last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours 91 215 22 8634 Maryl<u>and</u> Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at Florida Volusia 1 X Yes 2 No Daytona Beach Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 2545 South Atlantic Avenue #406 32118 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decadent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Property Management Office Manager 2 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F is marked of John Brannon Mollie White 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as
Important: If item 27 is
any injury or other trau Jackie Gast / Daughter 629 Dunberry Drive Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 5/5/2005 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. ciona manusous 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) difficil **Physician** lostrichum Nee /Medical Examiner Kecurrent arinar ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner tari entent Due to (or as a consequence of): Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? to Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 Probably 4 Nhknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ivision Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be 3 Suicide thin 24 hours after de the Funeral Director impletely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I complet the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 02, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mary land 31. Date filed Month, Day, Year) State Registrar

			1- State amend ite	State of M m #8 per	laryland / Depa fh g843 あん	artment of	f Health and ₹ Death		jien ë	5 15682
	Physici		Decedent's Name (First, Middle, Lass BURTON EHRLICH		D SR			2. Date of Dea Month May	7° 200	3. Time of Death 5:15P M
	/Medic Examir		4a. Facility Name (If not institution, give)	· -	n, or Location of De		4c. County of	Death
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	Director			ZM 2□F	75 Yrs.	Months Da	ys Hours Mi	September	10, 11,1929	Maryland
	yland 10W		Usual Residence of Decedent 10a. State 10b. County	**	10c. City, Town or Lo	ocation				10d. Inside City Limits
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	with th	Dire	10e. Street and Number 608 Wilton Road			10f. Zip Cod	e 286	1	0g. Citizen of Wha	at Country?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-1 ehow or other traumatic event, the Medical Exerting rough to notified at	d by Funeral Director	11. Marital Status 1 Never Married	12. Was Decedent Aymed Forces 1/1 Yes 2 If Yes, Give Year or Dates:	? Korea		of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian, White, etc. White
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Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, I'm Me	To Be	17. Father's Name (First, Middle, Last) William Frank Gree				G	ame (First, Middle, I ladys Ehr	lich	
Mar	id 2 should the and the modern of the modern		19a. Informant's Name/Relationship (7 Dorothy Wietscher	_{урв, Print)} Greenwood	d, Wife 608	ng Address (Str Wilton	eet and Number or I Road Tows	Rural Route Number on, Maryl	r, City or Town, Sta and 21286	ate, Zip Code) O
ore,	es 1 and of Health I itam 27 r other te		20a. Method of Disposition	Damas al fram Chata	20b. Place of Dispo cemetery, crei	osition (Name of matory or other)	place)	Date	20c. Location - Cit	y or Town, State
Baltimore,	permit. Pages Department of H Important: If its any injury or of		XX Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify) 1/	Druid Ri		etery 5/1			le, Maryland
Bal	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or othar trau		21/signature of Funeral Service Licen	Nena	Ris		6500	York Road B	altimore, I	eral Home Inc Haryland 21212
	Physician /Medical Examiner		23a. Part1. Enter the diserse, or companion, or heart failure. List only immediate Cause (final disease or condition resulting in death) Sequentially list conditions	a Due to (or a	la consequence of):)		Sclero	· ·	Approximate Interval Between Osset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
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l Vital		To Be	25. Was case referred to medical examiner? 1 Yes 22 No	Hospital: 1 Inpati	ent 2 ER/Outpatier	nt 3 DOA	Other	eath (Check only on Home 52 Reside		Specify)
ion of	Attanding Physic death. actor: After this by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		1 28c. Ir	njury at Nork? Yes 2 No		ow injury occurred	
Division	afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, office	ce	28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical (29a. Certifier Check only one)	vsicien: To the best iner: On the basis of and manner s	of my knowledge, death of examination and/or in tated.	n occurred at the vestigation, in m	e time, date and place by opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	/)		29c. Lice	ense number	2	9d. Date signed (M	fonth, Day, Year)
•	1		I Clelle		menns	V	56057	- [MAY 9,	2005
	22			ener, M	1830	Print)	Monument	Street;	Baltimon	50515 CM
	Sta Registr	_	31. Date filed (Month, Day, Year)	0 2005 N	ar's Signature	All Marie	7			

			1 - For Stata Registrar	State	of Marylar		artment <i>rtificate</i>			ind Me		giene Reg. No.	05	15683
	Physici	20	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	Day	Year	3. Time of Death
	/Medic		MILA E. GRAEF								MAY 4,	2005		10:45 P M
	Examin	ier_	4a. Facility Name (If not institution MARINER HEALTH	-			4b. City, To						ounty of Death	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Birtl (Month, Day	Year)	9. Birth	nplace (State or Foreign untry)
	Director		217-01-2083 Usual Residence of Decedent		70	Yrs.				Ma	ay 23,	1914	Mary	yland
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	h the Maryland r 28e-f show	ctor	Maryland Anne	Arunde1		Glen Bu	rnie							1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip C	Code				10g. Citizer	of What Cou	intry?
	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or Items 23e or 28e-f show event, the Medical Exeminer must be notified at		1907 Pagham Ro					2106				Unite	ed Stat	
	er de Items	Funerai	11. Marital Status	Armed F		.S. 13.	Was Decede f Yes, specif	nt of His y Cubar	spanic Orig n, Mexican,	jin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Amer Black, White	
35	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced	ed 1 Yes, G	2 🖎 No live Dates:		1□ Yes 2	No.	Specify:			Sp	pecify: WH	IJE
9500-612	2 hou		15. Decedent	's Education		16a. Dece	dent's Usual	Occupa	ition		T	16b. Kind	of Business/Ir	
Ž	within 72 ene. than "nat	Completed	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)		kind of work DO NOT use		luring most	of working	7			,
7	filed wil Hygien other th ent, Inc	Con	8			Но	memake	er					Own Ho	ome
land	uld be fill Aental H rkad oth tic even	Be	17. Father's Name (First, Middle, John Evans	Last)							First, Middle, Moore	Maiden Su	mame)	
\leq	is 1 and 2 should by Health and Ment Item 27 is marked of other traumetic e	2	19a. Informant's Name/Relations	nin (Tyne Print)		19h Mailir	ng Address /	Street a			Route Numbe	r City or Ti	oum State 7	in Codo)
Z	and 2 s ealth an n 27 Is ser trau		M. Lee Ritter /		r						Glen			21061
ā,	s 1 ar (Hea Item other	11 1	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of		Dat	te		ion - City or T	
altimore,	Page nent o nt: If		1 Burial 2 □ Cremation 4 □ Donation 5-□ Other (S)		n State	cemetery, cren DAR HII	-		. 1.1	lay 7, 2005	•	BROO	KLYN P	K., MARYLAN
Balt	permit. Pages 'Department of H Important: If Ite any injury or ot		21. Signal re # Fineral Service I	icensee		22 K	Name and	Addres	s of Facility	,	ERAL HC GLEN B			
Н			23a. Part1. Enter the disease, or	complications that	caused the deal								∠ ۱۱۱۷ و ـ	Approximate
	Physician		Immediate Cause (Final	only one cause on	each line.	:								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	o (or as a consec		ars		Dai	Mei	nlia			
	Examiner		Constitution of the second		,	,								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(UI da à CUII360	juence oi).								
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
Ď,	cian a	ai Ex	resulting in death) cast	Due to	o (or as a consec	juence of):							la la la la la la la la la la la la la l	
24/60	certificate be executed ding physician and use as the burial-transit	e G		d										
×	certif nding use a	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	ancy						234	. Date of deliv	100/
BOX	that the death ned by the atter detached for u	iciar	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 ☐ Feta nant at time of d		Ectopic pred Other (spec					230	Month Month	Day Year
j.	the by th ache	hys	9 Unknown	9□ Unk	nown									
z.	w requires that been signed b should be deta	by P	Part II. Other significent condition	ns contributing to	death but not res	ulting in the ur	nderlying cau	ise give	n in Part I.		23e. Did to	bacco use	contribute to t	the cause of death?
ğ	equire en si										1 🗆 Y	es 2 🗆 N	lo 3 ☐ Pro	bably 4 Unknown
Kecords	law as b	ompieted									24a. Was a		4b. Were auto	opsy findings available
	Th ate pag	Соп									perfor	med? 24 No	death?	2□ No
VITAI	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Literatel							Check on or		-	
O	Phys this al dii	2	1 ☐ Yes 2 🛣 No 27. Manner of Death			ER/Outpatien			4EN NUT		5 Resid			<i>(ty)</i>
	ling After fune	tion	1 XNatural 5 ☐ Pending		e of Injury nth, Day Year)	28b. Time of Injury	M 280	Work	aī ? ′es 2 ⊡ N		d. Describe h	ow injury o	ccurred	
UIVISION	deati ctor: y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be	e of Injury - At h	ome, farm, str			03 2 114		f. Location (S	treet and N	umber or Rus	ral Route Number.
2	al or / s after I Dire	Certification;	4 ☐ Homicide determi	build build	ding, etc. (Specia	ý)	oot, idotory, t	011100			City or Tow	n, State)	211007 07 71071	ar riodio riombor,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only one)	Physician: To the and ma	ne best of my kno basis of examina nner stated.	wiedge, death	occurred at restigation, in	the time	e, date and inion, death	place, and	d due to the c at the time, d	ause(s) and ate and pla	d manner as s ice, and due t	stated. to the cause(s)
	To thi within Fo the	Me	29b. Signature and title of certifier	3770 7770			29c. l	License	number		2	9d. Date s	igned (Month,	Day, Year)
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1	5		30. Name and address of person v					Սፐጥ	E 103	. GLF				D 21061
	Sta Registr		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature				, 555			THE LIAM	21001
	Licalon	"	MAY 1	0 2003	Mesua	D. 63	THE ST							-

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amend item#19,191, perfil in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie 🛭 🗍 🖔 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** EMIL GORDON MAY 8 2005 10:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/14/1931 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Yrs. 213-37-9539 74 UKRAINE Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If items 27 is marked other than "netural", or Items 23e or 28e-f show and it is the control of the c 1 Yes 2 No Completed by Funeral Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 271 OWINGS GATE COURT APT. #103 21117 UKRAINE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER METALLURGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MICHAEL GORDON ပ BETYA TYLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Soute Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 ts any injury or other trau once. SOFYA GORDON / WIFE OWINGS GATE COURT OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 05/09/2005 REISTERSTOWN, MD BALTIMORE_HEBREW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NCEK **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, loading to initial date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a gor securine of Examiner burial-transit To the Hospital or Attanding Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month 4 Pregnant at time of death 5 Other (specify) signed be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21 No 1 Yes 34 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deal To the Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vallan D28595 30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

Registrar

State

31. Date filed (Month, Day, Y

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State of Maryland / Department of Health and Mental Hygier [] 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2005 Rose Marie Greensfelder May 7, 12:50 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 Covered Wagon Road Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 13, 1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 250€ 66 Director 219-26-5242 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner roust be notified at 1 ☐ Yes 2☐No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 109 Covered Wagon Road 21220 U.S.A. or itams 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. withIn 72 hours efter 1 Yes 2010 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: 2 Specify: ₩Widowed 4 Divorced "natural White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Foster Care Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi h and Mental H 7 is markad ot Robert Louis Smith Helen Anna Spahn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 an Sandra Michael (Daughter) 401 Carrollwood Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard May 11,2005 Baltimore, Maryland ' 4 Donation 5 Dother (Specify) 21. Signature of Funer & Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in ath) Physician COrcinoma 2 /2 yours LYVE /Medical Due to (or as a conseconce of): **Examiner** Sequentially list conditions, if any, leading to immediate the line of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed and Due to (or as a consequence of): burial attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9☐ Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Completed 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2□ No 1 Yes 2 No 1 Yes Division of Vital Physician: 25. Was case referred to medical 26. Place of Death Check onl o examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Jeath 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After or Attending 1 Matural 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9,2005 D15546 llardes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Look Roven Blud, Baltimore, MD 21239 bodaett 31. Date filed (Month, Day State Registrar

	-	For State Registrar	State	of Ma	aryland /	Depa Cer	irtment <i>tificate</i>	of H	ealth a Death	ind M	ental Hy	giene Reg. No		5	15686
		Decedent's Name (First, Midd	fle, Last)							T	2. Date of De	ath			3. Time of Death
Physicia /Medica	_	George Hirso	ch .								Month May	Da 5			2:00P M
Examine		4a. Facility Name (If not institution	on, give street and n	um <i>ber)</i>			4b. City, T	own, or	Location of	f Death		40	. County of E	eath	
		Vantage House					Co1u						Howard	L	
Funeral Director		5. Social Security Number 098-07-1704	6. Sex 1⊠M 2□F	7. Ag	e (In yrs. last t	Yrs.	If Under 1 Months	Year_ Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di Sept.	ay, Year,		Count	ace (State or Foreign try) York
and *	- H	Usual Residence of Decedent 10a. State 10b. Count	v		10c. City, To	wn or Lo	cation							10	Od. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was De Armed F	orces?		13. V	Vas Decede Yes, specif	nt of His y Cubar	spanic Orig n, Mexican,	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - A Black, V		
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of Head		20a. Method of Disposition			20b. Place	of Dispos	sition (Name	of		- 1	ate		ocation - City	or Tov	wn, State
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s efter se ed in t	Certification:	4 Homicide	buil	ding, etc	c. (Specity)		,				City or To	wn, State	э)		
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U		30. Name and address of person	who completed cau	use of d	eath (Item 23a	(Type, I	Print) y ter	a	re	Coll	tumber 1	p.	10 2	o Ly	4/
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		1	For State Registrar	State of Mai		artment of F		, ,	giene	15	15687
Ė			Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death
	Physici /Medic	al	Regina Kathr					Month May		Year 005	12:34AM M
1	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deal	th	4c. County		
			Carroll Hospital				inster		Carı		
	Funeral Director		217-26-3432	M 2XF	(In yrs. last birthday)	Months Days	If Under 24 Hrs Hours Min.		r, Year)	9. Birthi Cou	place (State or Foreign ntry) MD
	pue *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	sho	5					_			ŀ	1 ☐ Yes 2 X No
	289-1	Director	MD Baltim 10e. Street and Number	ore	Re.	Lsterstowi	.1		10g. Citizen of V	Vhat Cou	ntni?
	with page						1.2.6				inity:
	ne 23	era	116 Hanover Road	2. Was Decedent Ev	ver in U.S. 13.		136 ispanic Origin? (5	Specify Yes or No-	14. Bac		can Indian,
36	within 72 hours after death with the Maryland ene. then "naturel", or teme 23a or 28e-f show the Medical Examinating the natilised at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	to Rican, etc.)	Specify	k, White,	etc.
Baltimore, Maryland 21215-0036	ture	ed	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu		White dustry
15	be filed within 72 hc tal Hygiene. d other then "natur event, ire Medica	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of wo	orking	70017(110 01 01		
212	r the	Eo	1 2	College (1-4or 5+		ousewife			Owi	n Hon	ne
פ	e filed within il Hygiene. other then vent, tre Me	Bec	17. Father's Name (First, Middle, Last)	· .			18. Mother's Na	me (First, Middle,	Maiden Surnam	re)	
<u>la</u>		To E	Henry F. Koenig				Frie	da Heint:	zman		
ary	d 2 should th and Men 7 is marke treumatic		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mail	ing Address (Street	and Number or R	ural Route Numbe	r, City or Town,	State, Zij	Code)
Σ	C = N L		Frederick N. Koeni	g, Jr. Nej	ohew 116	630 Red R	un Blvd,	Reister	stown, 1	4D 21	136
ore,	S		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	ce)	Date	20c. Location -	City or T	own, State
Ĕ	Pages nent of I int: If its ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Carroll (-	1	10/05	Hamps	tead.	MD
alti	permit. Page Department of Important: If any injury or otice.		21. Signature of Funeral Service License	9 /	2	2. Name and Addre	1		Reiste		
m	8 8 8 8		Jams &	line	E:	line Fune	ral Home	Reist	erstown	, MD	21136
			23. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused to	he death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Enysician		Inmediate Cause (Final Isease or condition	A50	- VID						Onset and Death
	/Medical	4	resulting in death)	Due to (or as a	consequence of):						icu,
	Examiner	П	Sequentially list conditions								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):						
	nd nd trans	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Clasese or Irju y that initiated events								
0,	e exe	EX	resulting in death) Last	Due to (or as a	consequence of);						
8760,	icate be executed physicien and s the burial-transit	dical								-	
9	leath certific attending p	Me	IF FEMALE:	3- H	(
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death 3	□Ectopic pregnancy	,			te of deliv nth	ery Day Year
o.	t the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me or death 5	Other (specify)					
<u>a</u>	that the od by detact		Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to t	he cause of death?
Vital Records,	Se ug	d by			•	,			′es 2 □ No	3 ☐ Proi	
jo	w require been si should I	ete						24a. Was	D4h	Alexa esta	G
Rec	has has	Completed						autop	SV I	orior to co death?	opsy findings available ompletion of cause of
a								1 🗆 Yes	2 No	Yes	2□ No
V.		Be	25. Was case referred to medical examiner?	ospital:		at 3 DOA Oth	00	ath (Check only o			
of	Phys rthis ral di	2	Yes 2 No 27. Manner of Death	28a. Date of Injury		III JE DON	4 LI Hursing	Home 5 Resid			fy)
on	ding h. h. After funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor	k?` Yes 2⊡No	200.000.00	ion injury occur	00	
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injur	y : At home, farm, s			28f. Location (S	Street and Numb	er or Rur	al Route Number,
Š	after Dire	Certification;	4 Homicide	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou	vn, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	(Check only 2 Medical Examin	sician: To the best of her: On the basis of and manner state	examination and/or in	nvestigation, in my o	pinion, death occ	urred at the time,	date and place,	and due t	stated. o the cause(s)
	o the	Mec	29b. Signature and title of certifier,			29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	->-0		11.40 lb	~		000	1924		M a	200	Vi)
•	0		30. Name and address of person who co	mpleted cause of de-	ath (Item 23a) (Tyne	Print)	71707	1 [Nay 9,	50	
	6		Herbert M. Henderse	n 5,40297	3 Manches	for RU	Monches	ter MO	2110	2	
	Sta Regist		29b. Signature and title of certifier. 30. Name and address of person who con the Nethodology. Hence 1. Hence 1. Sec. 31. Date filed (Month, Day, Year) MAY 1 0 26	105 32. Fistrai	's Signature	torde)					

		For State Registrar	State	of Mary	land / De	partment e <i>rtificate</i>	of H	ealth ar D <i>eath</i>	nd Me		iene (005	15688
Physicia /Medica	_	Decedent's Name (First, Middle RAE			EIGLE		HEN	IESON	2	MAY 6,	Day	5 Year	3. Time of Death 12:40 P M
Examine		4a. Facility Name (If not institution JEWISH CONVALE					TIMC	Location of I	Death			ounty of Death BALTIMO	RE
Funeral Director		5. Social Security Number 215-22-3094	6. Sex 1 □ M 2		yrs. last birtho	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,)9/14/1	Year)	9. Birthi Coul	place (State or Foreign htry) MD
Maryland f show	jor	Usual Residence of Decedent 10a. State 10b. County MD BALTI	MUDE	100	DALTI								10d. Inside City Limits
with the last or 28a-	Direct	10e. Street and Number			BALTIN	10f. Zip				1	0g. Citize	n of What Cou	X
urs a	by Funeral Director	48 STIRRUP CO	12. Was De Armed I	2 (Ž iNo Sive	in U.S.	3. Was Decede If Yes, speci 1 \(\text{Yes} \) 2	fy Cuba	spanic Origin	in? (Specit Puerto Ric	y Yes or No- can, etc.)		U.S.A Race - Americ Black, White, pecify:	
ed within 72 ho ygiene. ter than "netu	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	college	(1-4or 5+)	(G	cedent's Usual ive kind of work e. DO NOT use ALESPER	k done a e retired,	luring most o			RE	of Business/In	dustry
2 should be filed within and Mental Hygiene is marked other than aumatic event, the M	o Re	17. Father's Name (First, Middle, HARRY	Last)			SEIGLE		18. Mother's SARA		First, Middle, I	Maiden Su	umame) SHAP	I RO
1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relations HOWARD HENESON				ailing Address				Route Number		own, State, Zip	Code)
Pages 1 ar nent of Hea nt: If Item; iry or other		20a. Method of Disposition 1		n State	cemetery,	sposition (Namerematory or other	her place	9)	Date / 08/2	9		tion - City or To	
permit. Pages i Department of t Important: If Ite any injury or ot once.		21. Signature of Funeral Service	Licensee			22. Name and	Addres	s of Facility	SOL	LEVINS	ON &	BROS.,	INC. MD 21208
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line.	1000	enter the mode			ardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death 2 Gelli-
tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Discass or Injury that initiated events resulting in death) Last	c		nsequence of):								
the death certifica y the attending phached for use as t	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		birth 2 🗍	Fetal death	3 □Ectopic pre 5 □ Other (spe					230	d. Date of delive Month	ery Day Year
w requires that the de been signed by the s should be detached f	D Y	Part II. Other significant condition Esop	hogeel a										ne cause of death? ably 4 Unknown
The law requirate has been page 2 should	Completed									24a. Was ar autops perform 1 Yes 2	/	24b. Were auto prior to con death? 1 \(\sum \text{Yes}	psy findings available npletion of cause of 2 No
Physicia this certal direct	ation: 10 be	25. Was case referred to medical examiner? 1 □ Yes 2 □ √ 0 27. Manner of Death 1 □ Thattural 5 □ Pendin investig	g 28a. Date (Mo		2 ER/Outpa 28b. Tim Inju		c. Injury Work	r. 4 Nursi	sing Home 28d	5 Reside	nce 6 [Other (Specify	/)
To the Hospital or Attending 6 within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Ceruncauon	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Plac	ce of Injury - Adding, etc. (Sp.	At home, farm, pecify)	street, factory,	office		28f.	Location (Str City or Town	eet and N , State)	lumber or Rura	l Route Number,
he Hospl in 24 hou he Funer pletely fill	ealcai	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	g Physicien: To the Exeminer: On the and ma	ne best of my basis of exar nner stated.	knowledge, demination and/o	eath occurred at investigation, i	t the time	e, date and p inion, death	place, and occurred	I due to the ca at the time, da	use(s) an ite and pla	d manner as st ace, and due to	ated. the cause(s)
To the troop comp		29b. Signature and title of certified	1 + De	n	2	29c.	License		94		d. Date s	igned (Month,	Day, Year)
10		30. Name an address of person $SBRIB$	3/4 2	100	001011	des 1	1	_			5 /	md 2	1117
State Registra	-	31. Date filed (Month, Day, Year) MAY 1	0 2005	Registrar's S	ignature	Coarle	,						

			1 - For State Registrar	State o	of Marylan	id / Depa	artment rtificate	of H	ealth a	and M	ental Hy	giene Reg. No	- U U U	15	689
	Dhusisi	a n	1. Decedent's Name (First, Middle,	Last)							2. Date of Do	ath Da	у Үөа		of Death
	Physici /Medio		Lucille Berry	Harris							May	6	-		14 M
	Examin	er	4a. Facility Name (If not institution,	•	mber)		4b. City, To	own, or	Location o	of Death		4c.	. County of De	ath	
			1172 Tanager Dr						svill					Arunde]	
п	Funeral			6. Sex 1 □ M 2√5√F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under:	Min.	8. Date of Bi (Month, D.	rth ay, Ye <i>ar)</i>	9. B	lirthplace (Star Country)	te or Foreign
	Director		568-03-4784 Usual Residence of Decedent	387	91	118.					Dec.8,	1913		nsas	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Mary fish	ţ	Maryland Anne A	rundo l	M-i	illers	ri 110							1 🗆 Y	es 2 No
	7 28a	Director	10e. Street and Number	Laraci		LTTCLD	10f. Zip C	ode				10g. Cit	izen of What (Country?	
	h with	<u>=</u>	1172 Tanager Dr	ive			211	08				U.S.	Α.		
	deat	Funeral	11. Marital Status		edent Ever in U.	.S. 13.			spanic Orig	gin? (Spe	city Yes or No Rican, etc.)		14. Race - An	nencan Indian	
9	or Ite		1 ☐ Never Married 2 ☐ Marrie		2 X No		ires, specii 1 □ Yes 2[Specify:	i, Puerto i	Hican, etc.)		Black, Wh	nite, etc.	
ğ	ural',	d by	3 XWidowed 4 □ Divorced	Year or D	ates:			A 110	ороспу.				Specify: W	<i>h</i> ite	
Ϋ́	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fre Modical Examiner must be motified at	Completed	15. Decedent'. (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupat done du	tion uring most	t of workir	ng	16b. K	ind of Busines	ss/Industry	
2	withir ane. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +							1777			
р Б	filled Hygie other	ပိ	17. Father's Name (First, Middle, L	*	0+	Exect	<u>itive</u> S				(First, Middle		ucation	1	
a	d be antal ced o	o Be		,							l Humbe		Comamo,		
<u></u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	၉	John Wesley Ber 19a. Informant's Name/Relationsh			19b. Mailir	na Address (-					or Town, State,	Zin Code)	
<u>8</u>	and 2 sealth ar n 27 is		Christopher Whe		n)								, Md. 2		
စ်	1 and 2 1 Health Item 27 other tra		20a. Method of Disposition		<u> </u>	lace of Dispo					ate		ocation - City o		
9	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	emetery, crer Lingtor			- 1	257 21	5 200	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	lington	Vira	inia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event; If ite Marical Examiner must be nulliked at once.		21. Signature of Fundal Service) LULL	22	. Name and	Address	s of Eacility	ay 2.	5, 200	- 1	Lington	i, viig	IIIIa
ñ	Der Imp	6	160				407 0	Bru	zdzi	nski rn Av	Funera	HESSE	ome, P. ex, Mar	A.	21 221
	102		23a. Part1. Futor the 11 ease, or of shock, leart failure. List of	omplications that	caused the death								M, Plat	Approxim Interval E	nate
- 8	Physician		Immediate ause (Final	4.										Onset ar	
	/Medical		disease or condition resulting in death)	a. // Due to	(or as a consequence	uence of):	Lartonic	CAR	DIGUN	SCVLA	u bics	ASIL			
	Examiner		Sequentially list conditions.	b											
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequ	uence of):									
	ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c.											
8760,	death certificate be executed e attending physician and of for use as the burial-transit	i E		Due to	(or as a consequ	uence or):									
	physicate the t	dicai		d											
9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ncv							201 5-1		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live t	oirth 2 Fetal	death 3	Ectopic preg					1	23d. Date of de Month	elivery Day	Year
o.	that the dealed by the a	ıysi	1 ☐ Yes 2 12 No 9 ☐ Unknown	9□ Unkn		Jan 5 _	outor (spec								
о_	es that igned b	y P	Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the u	nderlying cau	se giver	n in Part I.		23e. Did 1	obacco u	se contribute	to the cause o	f death?
ds	requires that the reen signed by th hould be detache	d by	CLINICAL MIS	TORY ex	COLO	1 Tur	non				10	Yes 2	XVio 3□F	Probably 4 [∐Unknown
<u>0</u>	> D 0	iete		/							24a. Was	an /	24h Were s	autopsy finding	se available
Vital Records,	The law cate has b page 2 sl	Completed									auto		prior to death?	completion o	cause of
g	ilclan: Th certificate rector, pag	e Cc	25. Was case referred to medical						00 Bi	-4 Da -45	1 Yes	2 2000	1 □ Ye	s 2 No	
	ysician: is certific director.	0	examiner?	Hospital:	Inpatient 2	ER/Outpatien	2 DOA	Other			(Check only		SXIOther (Sp.	CCE	NTE
Division of	y Phys ar this eral di	n: To	27. Manner of Death		of Injury th, Day Year)	28b. Time of		: Injury a Work?			8d. Describe			ecity) SCE.	INC
0	nding tth. :: Afte	atio	1 Aatural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Injury	М		? es 2 🗆 ħ	No					
N N	il or Attending P after death. I Director: After t d in by the funera	iffice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Place	of Injury - At ho	me, farm, str	et, factory, o	office		2			d Number or F	Ru <i>ral Route N</i> u	ımber,
	al or A s after al Dire	Certification:	4 🗆 Homicide	Dulla	ing, etc. (<i>Specif</i> y	′)					City or To	wn, State)		
	To the Hospital or Attending Physician: Min. 24 hours after death as a file death To the Funeral Director. After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying (Check only 2 Medicel E	Physicien: To the	best of my kno	wiedge, death	occurred at	the time	, date and	place, a	nd due to the	cause(s)	and manner a	s stated.	
	the H in 24 the F plete	ledical	one)	kaminer: On the b and man	ner stated.	uon and/or inv	restigation, in	ту ори	nion, deat	n occurre	d at the time,	date and	place, and du	e to the cause	9(S)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-A /				icense	number			29d. Dat	e signed (Mon	ith, Day, Year,)
	4.			10	An A	SAPLE.	10	CME				May	, 9, 20	005	
1	4		30. Name and address of person w	o completed caus	se of death (Item	23а) (Туре,	Print)	_		_	1				
5			Dr. Upa Li				11 Pen	n St	treet	Ba	Itimor	e, M	aryland	1 21201	
	- CA-	te	31. Date filed (Month, Day, Year)	1	legistrar's Signat	ture	200								
T	Sta Registr	ar .	MAY 1 0 2												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JOHNSON Month May 5:45P M Physician WAYNE WENDELL /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NURSING CROWNSYILLE Hom EIf Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min (Month, Day, 9. Birthplace (State or Foreign 6. Sex / 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) Funeral Months Days Yrs. Director Usual Residence of Decedent 10d. Inside City Limit 10c. City, Town or Location 10a. State 10b. County 28e-f show other traumetic avant, the Madical Examiner must be notified at 1 ☐ Yes 2 No DASADENA Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 23a or 21122 KEEK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 Dyes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. or itams filed within 72 hours after BUACK WHITE 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 Widowed 4 Divorced "naturat" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " College (1-4or 5+) Elementary/Secondary (0-12) JOHNSON APPLIANCE SERVICE TECHNICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FFORD Pages 1 and 2 should be it of Health and Mental PAULINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MAIN CREEK NO 21122 8118 MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 Cremation BACTIMORE, MARY LAND 3 Removal from State permit. Page Department c Important: if any injury or once. ŏ ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE TUNERAL HM 21. Signature of Funeral Service Licensee BASIMORE NATIONAL DIKE BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? ŏ 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes 2**X** No 1 Yes or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 🔀 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No investigation death. Diractor: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel within 24 hours a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of MID

Registrar

State

Name and addre

th, Day, Year)

Highary alin Barnie 21061

leath (Item 23a) (Type, Print)

			1 - For State Registrar	State of Maryla		artment of F			ene 005	15691
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
	/Medic	cal	Phillip Ju			14 On T		<u> </u>	2005	1:50p M
	Examin	er	4a. Facility Name (If not institution, give Mariner Health		nde1		r Location of Deatl Burnie	1	4c. County of Dea	
	Funeral				rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Anne Ar	thplace (State or Foreign
	Director		213 30-7337	M 2□F -	71 Yrs.	Months Days	Hours Min.	OCT 8,		aryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mary First	tor	Maryland Harfor	d	Abero	leen				1 ☐ Yes 2 X No
	th the	lirec	10e. Street and Number		TIBOL C	10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	ral	1963 Mitchell D			2100			USA	
_	Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 📉 No	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
2-003p	hours after death with the Maryland turel; or Items 23a or 28e-f show at Examiner must be molitied at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
Ċ	2 2 2	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup	durina most of wor	rking	6b. Kind of Business	/Industry
7	withi ane. than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		ne Operat	-/		Comatu	want day
N D	T) CD	O	17. Father's Name (First, Middle, Last)		OL6	me operat		ne (First, Middle, M.		ruction
lan	should be nd Mental marked c	To B	Phillip Jones				Julia H	Tahey		
Mar	2 6 8 9		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, a	Zip Code)
ຜົ	other tr		Michael D. Jones 20a. Method of Disposition		. Place of Dispo	Mitchell sition (Name of			MD 21001 Oc. Location - City or	Town State
Ď.	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State		matory or other place ematory,	· 1		Baltimore	
altimor	permit. Pages of Depertment of Hamportent: If ite any injury or of once.		21. Signature of Funeral Service Licen					of Maryla		, 1112
מ	Ded Per Per Per Per Per Per Per Per Per Per			Donald	1.2	99 Freder	rick Road	Raltimo	re. MD 21	228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de one cause on each line.	eath. Do not en	ter the mode of dyin	ng, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	andiae	- Harh	Muria			minutes
	Examiner			Due to (or as a cons	equence or):		3			
	р . इ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):					
	be executed ician and burial-transit	Examin	Causa (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):					
8/60,	cate be executed physician and the burial-transit			4	34001100 31).					
20	certificate Iding physise as the	hysician/Medical		d	200			7.5		
X Q Q	ith cert tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of del	
	the atten	ysici	1 Yes 2 No	4□Pregnant at time o 9□Unknown	f death 5[Other (specify)			Month	Day Year
ŗ.	w requires that the death certific been signed by the attending pl should be detached for use as t	٥.	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ras,	quires en sigr uld be	ed by	Ahid Johnill					1 🗌 Yes	2 □ No 3 □ Pr	obably 4 Unknown
ပ္	law re as bee 2 sho	ompleted	Chrome Short	notice Pulo	7	discore		24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
	: The law cate has l	Con			0			perform	death? No 1 ☐ Yes	
VITAI	Physician: The this certificate ral director, pag	Be o	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only one		
ō	g Phys er this eral dir	n: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	28b. Time o	IL 3 DOA	4 Nursing H	ome 5 Resident 28d. Describe how	ce 6 Other (Special of the Control o	cify)
lo	ending P lath. or: After I he funera	atio	1 Natural 5 Pending investigation		Injury		Yes 2 □ No			
UIVISION	or Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Ai building, etc. (Spe	t home, farm, st cify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
)	To the Hospitel or Atlanding Pl within 24 hours after death. To the Funerel Director: After it completely filled in by the funera	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, deat	h occurred at the tin	ne, date and place	and due to the cau	ise(s) and manner as	stated
	ne Hoo n 24 h ne Fur pletely	edical	(Check only 2 Medical Examone)	iner: On the basis of exami and manner stated.	ination and/or in	vestigation, in my o	pinion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	To the To the comp	×	29b. Signature and title of certifier	100		29c. License			d. Date signed (Mont	
,	10		P /1500	5			40271		in any 1/2	001
1-	11		30. Name and address of person who o		tem 23a) (Type,	Print) 325	Hospite	1 Brive	May 9,2 Suite 20 a 21061	38
Ì	Sta	ite	31. Date filed (Manth Pay, Year)	5 2. Registrar's Sig	nature		y and a	me (11	-1001	
	Registr	ar	WAL TO 500	Jan Jan Sa	N ASSOCIA					

amend item#11,20b, perint in Black-Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ohns Day **Physician** Month Year Theresa 2005 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE GLEN ANNE NO2TH ARUNDEL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 28, Year | 27, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Year | 1, Y 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖾 F 77 217-24-8974 Director 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itema 23a or 28a-f ehow 1 ☐ Yes 2 ☒ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8013 Quarterfield Rd. 21144 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 25 Wildowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry le marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental William Goedeke Ursula Mackemull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If Item 27 le any Injury or other trau Andrew Johns / Husband 8013 Quarterfield Rd., Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 11 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 2005 Glen Haven Mem. Park Glen Burnie, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Emer the Visease, or complications that caus + 1 shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by the aid 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No 1 🔲 Yes To the Hospital or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Inpatient 25/No 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 T Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 AGADDA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of He			iene 005	15693
	Physici		Decedent's Name (First, Middle, Las Paul George K					2. Date of Death		3. Time of Death 19,34 M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City-Fown, or 1	ocation of Death	5	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 216-10-1270 Usual Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 30	year) 9. Birth Col , 1920 Mar	place (State or Foreign intry) yland
	e Maryland 8a-f show diffed at	Director	10a. State 10b. County Maryland Baltim		Caton	sville				10d. Inside City Limits 1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number 327 Concert Way			10f. Zip Code 2122	00	10	U.S.A.	intry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23c or 28a-1 show any injury or other traumatic event. The Medical Examinar must be rediffed at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 12\$Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
21215-0036	ithin 72 hou ne. nan "naturai a Medical E	Completed t	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of work	ing	16b. Kind of Business/I	ite ndustry
	Hygier ther thint, int, int, int.		17. Father's Name (First, Middle, Last)	2	Vice	President	of Bank 18. Mother's Name	(First Middle N	Banking Maiden Sumame)	
lan	Mental Mental rked o	To Be	Paul Krabitz				TO MOUNT O FRANCE	(r mai, rendard, re	and Carraine)	
, Maryland	and 2 shorestiff and No. 27 is ma		19a. Informant's Name/Relationship (7 Mark Krabitz (Гурв, Print) (Son)		ng Address (Street ar Concert Wa			City or Town, State, Zi	
nore	ages 1 and of He in: If Item y or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crei	sition (Name of matory or other place)		20c. Location - City or T Marriottsvi	
Baltimore,	permit. F Departme Importar any injur		21. Signature of Funeral Service Licen		2 8	Name and Address	of Facility Pral Home	of Cato	onsville, I Ville, Mary	nc.
68760,	/Medical be executed / Medical Examiner Street Properties Physician and Street Properties Physician and Physician an	dical Examiner	23a. Part1. Enter the disease, or compand shock, or heart failure. List only of the shock of the	one cause on each line.	equence of):				- DJ6676	Approximate Interval Between Onset and Death
P.O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ital death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
	sign d be	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giver	n in Part I.		acco use contribute to	_
Vital Records,	The ate h	Completed						24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	y prior to co	opsy findings available ompletion of cause of
Z.	Physiqian: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☑ER/Outpatier	Othor	26. Place of Death	17 17 17	nce 6 □Other (Spec	4.1
Division of	ding After fune	Certification; T	27. Manner of Death Natural 5 Pending Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Injury Work			w injury occurred	197)
DIV	ital or Attend rs after death ai Director: led in by the f	Certifi	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nation and/or in	vestigation in my oni	nion death occurr	ed at the time da	to and place and due at	to the cause(c)
	To t To t	Σ	29b. Signature and title of certifier	0		29c. License	number 2	29	9d. Date signed (Month)	Dey, Year)
1	0		30. Name and address of person who	completed called of death (Its	em 23a) (Type.	Print)	8>2	1	viay 5, 2	Dey, Year) LODS LIZZZT
	Sta		31. Date filed (Month, Day, Year)	32 Begistral's Sig	nature /	books	U Lat	on Av	enve Dal	TIMARE
12	Regist	ar	MAT.	I O COURT TOTAL	955 F	17				

State of Maryland / Department of Health and Mental Hygiere 15 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2005 Kinna 9:55 P M Gladys Vivian Spring /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Garden House at Edenton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State of Birth Aug. 18, 1910 | 1910 | Mary Land 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 94 219-68-2681 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marie Executation. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 U.S.A. 5849 Genesis Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine James Elias Spring Mary Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6133M Springwater Place, Frederick, Maryland 21701 Sue Marie Kalons- Daughter 20c. Location - City or Town, State 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg Methodist Cemetery 5/10/05 Clarksburg, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Size) 20872 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 100 disease or condition resulting in death) /Medical Due to lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached the 9 Unknown 9 Unknown by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown LMLY Completed Deec 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No has certificate 1 ☐ Yes 28 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Livin Hospital: 1 Yes 2 XNo 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Alter Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a To the Funeral D i 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 1/2001

State Registrar

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2005 KHTOMil Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Days Hours 1 M 2□F 27 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND JARRETTEVILLE HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BRONSON LOURT 3137 48016 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 25 Married 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 31iltw 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 127RS IAMABER DILLER GOHLE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) 0,000000 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and State 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) JAIRT L. JARRETTVILE MARILAND 20a. Method of Disposition 20c. Location - City or Town, State Date MAYIL 1 ☐ Burial 2 Cremation 3 ☐ Removal from State FOREST HULL PARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility HASI - BEL RIR, C.A. 3. NEWFORT DRIFE FORESTHILL MAR 21. John Fundal Serve Lichsee TO 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Certenoscherotic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE:

Physician /Medical Examiner

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funeral director, page 2 should be detached

After this

Director: filled in by the

To the Hospitel or within 24 hours af To the Funeral D

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Be Completed

Certification: To

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The law requires that the death certificate be executed

Hospitel or Attending Physicien:

Department of Importent: If It any injury or o

Physician

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Completed by Funeral

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28a-f

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Pages 1 and 2 Health Item 27 I

Maryland 21215-0036

Baltimore,

other treumetic event, the Medical Erand sermust be notified at

Examiner Physician/Medical

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part
11 h		, , ,

3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2

√ No 1 Tes ck only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

Was case referred to medical examiner?				26. Place of Death (C	heck only one)	
1 Yes 2 No	Hospital: 1 Inpatient	2 X EP/Outpatient	3□ DOA	Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)

27. Manner of Death 1 Natural 2 Accident 5 Pending

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 Suicide

4 Homicide

29c. License number

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiers

investigation

M014206

29d. Date signed (Month, Day, Year)

30. Name and address of erson o completed cau e of death (Item 23a) (Type, Print) MD DONE J.

Registrar

completely

31. Date filed (Month, Day, Year) MAY 1 0 2005



		1 _ State	partment of Health and Mertificate of Death	ental Hygie	ne
		1. Decedent's Name (First, Middle, Last)	Timcale of Death	Reg.	No. UU 3 3 Time of Death
Physic		FRANCES JEANETTE KEY		Month	Day Year
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 4, 2	4c. County of Death
		UNION MEMORIAL HOSPITAL	Baltimore City		N/A
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
Director	4	215-07-8680 1 M 2XF 87 Yrs. Usual Residence of Decedent		Aug 26,	1917 Washington,DC
ryland how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Ba-fs	cto		more City		1 V Yes 2 1 No
INTIMOTE, INIGITYIGHTIC ZIZIO-UUSO init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evaninar market pricitied at injury or other traumatic event, the Medical Evaninar market political at	Funeral Director	10e. Street and Number 3838 Roland Avenue	10f. Zip Code 21211	10g.	Citizen of What Country? USA
ns 23	eral			cify Yes or No-	14. Race - American Indian,
after or item		Armed Forces? 1 \(\subseteq \text{Never Married} \) 2 \(\subseteq \text{Married} \) 1 \(\supseteq \text{Yes}, \text{Size } \text{No} \) ff Yes, Give \(\Lambda \)	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
hours af	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
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Pages Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)		duct care or va
Dallimor permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	Mem. Park 15/14/ 22. Name and Address of Facility		ltimore, Maryland
Depa Impo		Martin D. Lawson	Mitchell-Wiedefeld		
		Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not es shock, or heart failure. List only one cause on each line.	her the mode of cyling, such as cardish of	respiratory arrest	Maryland 21212 Approximate Interval Between
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Ords, F.O. BG requires that the death een signed by the atter hould be detached for u	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
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	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FVOutpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Hon		e 6 □Other (Spacify)
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or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rural Route Number, State)
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, dea	ith occurred at the time, date and place a	and due to the caus	e(s) and manner as stated
ne Hos 1 24 h ne Fur	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
~ <		Islam on 40	735102	m	AV 5 2005
8 1		30. Name and address of person who completed cause of death (Item 23a) (Type			. (0)
	tato	Hilary Don, M.D., 104 Tunbridge Roa 31. Date filed (Month, Day, Year) 32. Registar's Signature	d, Baltimore, Maryl	land 2121	2
Regis		MAY 1 0 2005 Deser &	Maria		
8 \ s	tate	30. Name and address of person who completed cause of death (Item 23a) (Type Hilary Don, M.D., 104 Tunbridge Roa	735102	m	AY 5, 2005

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 14 Year Physician SETTY LACHNER 2005 8:40 p.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5401 Old Cooked Road Baltimoise northwest Hospital Randallstown, MI) 8. Date of Birth (Month, Day, Year) Jan. 8, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🖫 F 218 44 2083 60 1945 Director North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event. The Medical Examiner must be notified at 1X Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 5437 Old Frederick Road U.S. 21229 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Its Na. Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (not available) Alethia Norris Brooks Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Lachner / Husband 5437 Old Frederick Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 5/13/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTILOBAR PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chromic Obstructive pulmonary disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 ☐ Yes 2 € No funeral dis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier at Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier may 8th 2005 D54288 bramarwany 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

MAY 1 0 2005 Been S. Sperle

			for State Registrar	State of Ma	•	•	or Health a of Death	ing Mental H	Reg: No. 0 5	15698
			1. Decedent's Name (First, Middle, La	st)				2. Date of D Month		3. Time of Death
	Physicia -/Medic			DWIN LLOYD	1			May	7, 2005	11:13P M
	Examin		4a. Facility Name (If not institution, giv				Town, or Location of	f Death	4c. County of	
			814 Mockingbird		102		SON	24 Hrs 0 Days 4 B		imore County
	Funeral Director		5. Social Security Number 6. S 213-48-1878 Usual Residence of Decedent	M 2□F	56 Y	Months rs.	Days Hours	Min. 8. Date of B (Month, D Dec 2	7, 1948	Birthplace (State or Foreign Country) Ohio
	land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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	r 28g	irec	10e. Street and Number	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10f. Zip			10g. Citizen of Wh	at Country?
	th wit	Funeral Director	814 Mockingbird	Lane, Apt	102		21286		US	SA
	ems ems	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Deced	ent of Hispanic Ori ify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. Race - Black.	American Indian, White, etc.
3	filed within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or flems 23a or 28a-f show after then then then then after interest the modified at any or the the modified at any or the flew of the modified at any or the flew of the modified at any or the flew of the flew	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2	No Specify:		Specify:	White
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ā		2	Dale Edwin Llo	yd				Adelaide E	. Krone	
8	2 sho and Is ma		19a. Informant's Name/Relationship (Mailing Address	(Street and Number	r or Rural Route Num	ber, City or Town, St	tate, Zip Code)
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bannore,	permit Depart Import any in		21. Signative of Funeral Service Licen			Mitche	11-Wiede	eld Funera	al Home, 1	Inc.
	= 1000	22.1	Martin D. Law 23a. Part. Enter the disease, or com shock, or heart failure. List only	SUII	the death. Do n	6500 Y	ork Road	Paltimore cardiac or respiratory	arrest. Marylar	nd 21212 Approximate Interval Between
,007	Physician // Medical be executed by National and step private transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	cons « uen le consequence o a consequence o	J) C			> 10 year
O. BOX 60	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the little of the l	2 Fetal death	3 □Ectopic pro			23d. Date Month	
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	ding Phys h. After this funeral dir	- To	1 Yes 2 No	1 ☐ Inpatie	nt 2 ER/Out		A 4 Nu Bc. Injury at	rsing Home 28d, Describe	sidence 6 \(\text{Other} \) The how injury occurred	
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5	Atten	ertifica	4 Homicide							
5	Hospital or 4 hours afte Funerel Dir ely filled in	dical Certification;	29a. Certifier 1 Sertifying Pl	hysician: To the best of miner: On the basis of and manner sta	examination and	death occurred	at the time, date an in my opinion, dea	d place, and due to the th occurred at the time	e cause(s) and manr e, date and place, an	ner as stated. d due to the cause(s)
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DIVISION OF	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: After completely filled in by the fun	edical	29a. Certifier 1 Gertifying Pl (Check only one) 2 Medical Example	miner: On jhe/basi/s of	examination and	/or investigation,	in my opinion, dea	d place, and due to the	, date and place, an	d due to the cause(s)
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	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dealtimore	ath	4c. County of Dea	ath
	Funeral Director		Joseph Richey Hospice Inc. 5. Social Security Number 6. Sex 1 M 2 K F 82	s <i>t birthday)</i> Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Mi		y, Year) C	rthplace (State or Foreign country) SC
ī	and *		Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Lo	ocation			10d. Inside City Limits
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	r 28e-	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?
	th with	ai D	6401 Loch Raven Blvd Apt 4	21	21239		U.S	. A .
20	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Menta! Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other traumatic event, the Marical Examinat must be notified at or other traumatic event, the Marical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowled A Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes XXNo Specify:	(Specify Yes or No erto Rican, etc.)		
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7	within then	шо	Elementary/Secondary (0-12) College (1-4or 5+) 7th grade na		mestic Worker		Priva	te
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importents: if item 27 is marked other than any injury or other traumatic event, II a M. 2016.8.	Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle,	, Maiden Sumame)	
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Maryland	2 sho and is ma	0.0	19a. Informant's Name/Relationship (Type, Print)		ng Addrass (Street and Number or			
	Health tem 27 tother tra		Joyce Ann Nelson-Daughter 20a. Method of Disposition 20b. Pla		6 Winston Ave	, Balti	nore, Ma,	
saltimore,	nt of h		NSBurial 2 ☐ Cremation 3 ☐ Removal from State	metery, cre	matory or other place)	1		
	permit. Pages I Department of H Importent: If ite any injury or ot ance.		21. Signature of Fun all Struce Licensee		morial Park 5, 2. Name and Address of Facility	/11/05	Randalls	town, Ma
m m	Departiment Department Important Important Income.		1 Minoste K-me	M	arch F/H West	o Dolt:	bM czemi	21215
г			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart ailure. List only one cause on each line.	Do not en	300 Wabash Average the mode of dying, such as card	iac or respiratory a	rrest,	Approximate Interval Between
	Physician				tic cancer			Onset and Death
	/Medical		resulting in death) Due to (or as a conseque		rearica			WEEK
	Examiner	L	Sequentially list conditions, b.					
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	moe of).				
_	be executed ician and buriat-transit	Examiner	that initiated events c. The state of the st	ence of):				
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289	ifficate g phy as the	ledic						
P.O. Box	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the b	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dear 9 ☐ Unknown	death 3[□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year
	s that	y P	Part II. Other significant conditions contributing to death but not result	ting in the u	inderlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires that been signed to should be deta	edt	Coronary artery disease			1 🗆 '	Yes 2□No 3□F	Probably 4 Minknown
Records,		complet				24a. Was auto perfo	psy prior to death?	autopsy findings available completion of cause of s 2 No
Viital	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?			eath (Check only o	one)	. /
of	> 0	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie		Home 5 Resi		ecity) Has fice
Division	fter	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28b. Time o Injury	Work? M 1 ☐ Yes 2 ☐ No		how injury occurred	107
Σ	ital or Al	Certif	4 Homicide determined 286. Place of injury: At non building, etc. (Specify)	1		City or To		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 'Certifying Physicien: To the best of my know 2 Medicel Examiner: On the basis of examination and manner stated.	ledge, deal on and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ice, and due to the ccurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th Within To th	M	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
)	de		* E HO MD		024170		May 6,	2005
	U O		30. Name and address of person who completed cause of death (Item: E.TSO MD Richey Huspice	23a) (Type 838	N. Entaw S	+ Ba	May 6, Hinore	MD 21201
		ate	31. Date filed (Month, Day, Year) 32. Reg trar's Signatu	The H	hode			
	Regist	A y	MAI I V 2043 Julian	,				
DH	MH 17 Rev 1/2	2001						

			For State Registrar			f Marylan		artmen rtificate					Reg. No.	005	15700
	Physici	an	Decedent's Name (First, Middle	, Last)							2. Date of D Month	eath Day	Year	3. Time of Death
	/Media		Nelson			McCoy			Mil			May	07_	2005	1243 PM
	Examir	er	4a. Facility Name (If n			,				Location		U	4c.	County of Dea	ith
			Mercy St 5. Social Security Num		Maris E	7. Age (In yrs.		If Under		More		0 Data of B	inth	0.5:	
	Funeral Director		218-22-3	098	1 X) M 2□F	7. Age (iii y/s.	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D			thplace (State or Foreign ountry) VA
	and * _		Usual Residence of D 10a. State	ob. County		10c. Cit	y. Town or Lo	ocation							10d. Inside City Limits
	Aaryis I sho	5	MD	N.A			Baltir								XIXYes 2 □ No
	death with the Maryland ms 23s or 28e-f show ITRUST DE FOUITIES ST	Funeral Director	10e. Street and Numb		4		parti	10f. Zip	Code				10a Citi	zen of What C	
	with Sa or	<u>=</u>	1627 Rux		\ ***			101. 2.5		1216			rog. Oiti		•
\leq	Jeath The 20	era	11. Marital Status	COIL	12. Was Dec	edent Ever in U.	.S. 13.	Was Deced				ecify Yes or N	lo-	U.S. A	
Sin	r Iter	Fun	1 Never Married	2 Marri	Armed For ed 1 ☐ Yes If Yes, Gir							ecify Yes or N Rican, etc.)		Black, Whi	
33	ours a	b	3 ☐ Widowed 4	□Divorced	If Yes, Gi Year or D	vē ates:		1 ☐ Yes 2	X No	Specify:				Specify:	Black
5.0	72 hc	Completed	1 (Specify	5. Decedent	's Education t grade completed)		16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of work	ina	16b. Kir	nd of Business	
27	ithin	npie	Elementary/Second		College (1-4or 5+)	life.	DO NOT us	e retired))	it or work	g			
2	led w lygier har th		12th gra	de	na		St	eam	Fit				Har	lem Ho	spital
and and	be fill	Be	17. Father's Name (Fi									First, Middle		Sumame)	
<u>- 3</u>	should ind Men inarke umatic	1°	Abraham				101-14-11		(0)			M. Re			
Miles Maryland	d 2 st th and 7 is r traun		19a. Informant's Nam											r Town, State,	
	1 and Health om 27		Carolyn 20a. Method of Dispos		s-Daught	20b. P	Place of Dispo	sition /Nam	e of	1		, Bali Date		re, Mo	
JO.	ages int of t: If It		•	Cremation	3 Removal from	State	emetery, crei				E /3	0 /05			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23s or 28e-f show any injury or other traumatic event, the Mudical Experiment must be notified at ance.		21. Signature of Fune			Kin	ng Men	2. Name and	Addres	s of Facilit	tv				own, Md
Ba	permi Depa Impo any ir		1.01	(MO	C. N	VIMDEO	Me Me	rch	F/H	Wes	t	Balt	·		01015
			23a. Part1. Enter the	disease, or	complications that of	aused the deat	h. Do not ent	er the mode	apa of dying	SN_A g, such as	cardiac o	Balt:	l More arrest,	e, Ma	21215 Approximate
	Physician		Immediate Oalise (Fi		only one cause on e	each line.	1								Interval Between Onset and Death
	/Medical		resulting in death)		a	(or as a conseq	uence of):	<u>5</u>	CU	ハル					
	Examiner		Commentally list one of	Min	b										
	D ==	ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj	ediate	Due to	(or as a conseq	uence of):								
	acute ind trans	Examiner	Cause (Disease or inj that initiated events resulting in death) Las		c										
50,	rate be executed thysician and the burial-transit		rosoning in douting cut		Due to	(or as a conseq	uence of):								
8760,	physic the t	Physician/Medical			d										
9 ×	teath certifica attending ph	/Me	IF FEMALE:		23c If yes out	come of pregna	ency								
Вох	atten for u	cian	23b. Was decedent p	onths?	1 ☐ Live t	oirth 2 ☐ Feta	Ideath 3	Ectopic pre					2	3d. Date of de Month	Day Year
P.O.	that the de led by the s detached t	ysi	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	No	9□ Unkn		0417	2 011101 (350							
₫.	Attending Physicien: The law requires that the death certificate r death. ector: After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the	by Pł	Part II. Dther significa	ant conditio	ns contributing to d	eath but not res	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did	tobacco us	se contribute to	the cause of death?
rds	w requires been sig should be											10	Yes 2	No 3 P	obably 4 Unknown
၀	aw requ s been 2 should	Completed										24a. Was		24b. Were au	utopsy findings available
æ	The law te has	L O										auto perf	ormed?	prior to death?	completion of cause of
ia	ian: rtifica ctor, p	Bec	25. Was case referred	d to medical						26. Place	of Death	(Check only		10.00	2010
>	nysic nis ce	2	examiner?		Hospital: 1 🗆	npatient 2	ER/Outpatier	nt 3□ DO	A Othe	er: 4 □ Nu	ırsing Hor	me 5 Res	idence 6	Other (Spe	city) hospite
0	ng P	on:	27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	4	28d. Describe	how injury	occurred	
sio	death. ctor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investig	ot be			M		/es 2 □ l					
Division of Vital Records,	l or Atlanter of Direction by	Certification:	4 Homicide	determi	ned 289. Place	of Injury - At ho ng, etc. (Specify	ome, tarm, str	eet, factory,	office		2	City or To	(Street and wn, State)	Number or Ru	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 (Check only 2	Certifying	Physician: To the examiner: On the b	asis of examina	wledge, death	n occurred a	t the tim	e, date an	d place, a	and due to the	cause(s) a	and manner as	s stated.
	within 2 To the	Mec	one) 29b. Signature and titl		and man	ner stated.				number				signed (Mont	
	d		1	VV	~ ~	0				DO	108	154		5/9	2003
1	1		30. Name and address	1	vho completed caus	e of death (Item	23a) (Type,			(+	D	191	C	Himor	21207
	Sta	te	31. Date filed (Month,	Day, Year)	32. B	egistrar's Signa	ture	- 'S	(ن	5+.	11-	1 1 1	154	114174	0.0.2
	Registr		N	AY 1 C	2005	egistrar's Signa	& A	ares.		_					

			Please 1		lack Indelible Ink. Ensu	=	•	
			1 - For State Registrar	State of Maryland	I / Department of Health a Certificate of Death		giene 005	1570
	Physicia	an	1. Decedent's Name (First, Middle, Last	1	ITP	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of	of Death	3 200.	
			CALSTER BALT, 5. Social Security Number 6. Se	more Medical	Leute Towson	N	DALTIN	107E
	Funeral Director			M 200 F	Yrs. Months Days Hours	Min. (Month) Day	y, Year) C	Way Lard
aryfano	show del	_	10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
th the Ma	or 28a-f	Funeral Director	10e. Street and Number	none R	10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2 No
ath w	s 23a	ral	2 Latimo		212	37	USI	7
within 72 hours after death with the Maryland	l', or Item veπiner n	by Fune	11. Marital Status 1 ▼ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 If No Specify: 		14. Race - Ame Black, Whi	
72 hou	natura IIcel E	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a. Decedent's Usual Occupation	t of working	16b. Kind of Business	Industry
l D	Hygiene. ther than "r int, I're Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	t of working	NA	
ed blu	Mental Irkad o	To Be	17. Father's Name (First, Middle, Last) Dowald 19a. Informant's Name/Relationship (Ty	D. Carther	TIL 1	or's Name (First, Middle,	Moi	IRISON
and 2 s	27 is me r traums		SBMC PATH)L067	19b. Mailing Address (Street and Number	ST. BUT	MORK MD	212 M
	of Health If itam 27 or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 F		ace of Disposition (Name of metery, crematory or other place)	Pate	20c. Location - City or	Town, State
. Pages	Department Important: I any injury o once.		' 4 ☐ Donation 5 ☐ Other (Specify)	16K	EEN MOUNT	5 7 2005	DALTIMOR	E, MD
permit	Depar Impor any in		21. Signature of Funeral Service Licens	eee ·	22. Name and Address of Facility	PHENRY W.	DENKINS +	50NS CO.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.	Do not enter the mode of dying, such as	cardiac or respiratory ar	rest,	Approximate Interval Between
/	ysician Medical		Immediate Cause (Final disease or condition resulting in death)		CATIVE Septicem	in		Onset and Death
E	caminer	_	Sequentially list conditions,	. TNEUMONI	13			3 days
petr	insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):			
be executed	sician and burial-transit	al Exa	resulting in death) Last	Due to (or as a conseque	ence of):			
	physic s the b	edlca		d				
The law requires that the death certificate	igned by the attending phys be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decorated by □ Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
ires that t	signed by d be detac	by Ph	/		tting in the underlying cause given in Part I	/ \	obacco use contribute to	o the cause of death?
he law requires t	been s	letec	Deca Patrons	- To see	gestational age AT	24a. Was	- 1	utopsy findings availabl
The la	ate has page 2	Completed by	VESPINOTION C	SISTRESS S	yw a nome	perfo	prior to death?	completion of cause of
Physician: T	ector,	Be	25. Was case referred to medical examiner?	Manitali .		of Death (Check only o		
. Ę	r this o	To To	1 Yes 2 No	28a. Date of Injury	R/Outpatient 3 DOA Other: 4 Nu 28b. Time of 28c. Injury at	ursing Home 5 Resid	dence 6 Other (Spe	əcify)
nding	ath. r: Afte le fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐	i	iow injury occurred	
To the Hospital or Attanding	within 24 hours after death. To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (5 City or Tow	Street and Number or R vn, State)	ural Route Number,
liqsoH et	n 24 hour na Funara sletely fills	Medical (29a. Certifier 1 ➤ Certifying Phy (Check only one) 2 ☐ Medical Exem	rsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death occurred at the time, date an on and/or investigation, in my opinion, dea	nd place, and due to the outh occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To th	To the	ž	29b. Signature and tille of certifier.	7-01	29c. License number		29d. Date signed (Moni	th, Day, Year)
			p poul C	whis	D288	85	5/4/	05
		1	16 Wald L. Siere	ompleted cause of death (Item	23a) (Type, Print) 1 N. Charles St. ure	Rolt 1	nd 1.	204
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ure	1874, 11	1111 2/3	

Registrar

MAY 1 0 2005

			1 _ State		partment of Health and I ertificate of Death		2000	15702
	_		Registrar 1. Decedent's Name (First, Middle, Last)	0.	erinicale of Dealir	2. Date of Death	J. No.	3. Time of Death
	Physici /Medic		ADFLAIDE 1	MARIE Mo	egan	Month 5	Day Year 5 2005	& ISD M
	Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death		4c. County of Death	
			2825 ONYX RD		PREKULLE		RALTIN	MORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	(ear) 9. Birth	place (State or Foreign intry)
ļ.	Director		Usual Residence of Decedent	Yrs.		5.2.19	125 PEN	wasy Wardin
	land ow		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mary Feb	ţō	MD BALTIMO	RE P	ARKIMLE			1 Tes 2 No
	or 28s	Funeral Director	10e. Street and Number		10f. Zip Code	10g	3. Citizen of What Cou	intry?
	238 c	alD	2825 ON/X	KOAD	21234		() SA	
	r dea	Iner	Ann	s Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
2	s afte	by Fu	If Y	Yes 2 No es, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: V	10.=
3	hour	ed b	15. Decedent's Education	r or Dates:	cedent's Usual Occupation	10	bb. Kind of Business/Ir	PHILE
2	n "ne	plet	(Specify only highest grade comp	leted) (Gir	ve kind of work done during most of work. DO NOT use retired)	king	D. Kind of business/il	idustry
7	d with	Completed	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	tome maker		own i	Home
3	should be filed within 72 hours after death with the Maryland Ind Menial Hygiene. marked other than "natural", or liema 23a or 28a-f show matic event, the Medical Exam. ar must be indiffied at	BeC	17. Father's Name (First, Middle, Last)	0	18. Mother's Nam	ne (First, Middle, Ma	uden Sumame)	
la	Menta	To	John Edward	Keynold	\sim \sim	rie r	narx	
0	2 sho and Is my		19a. Informant's Name/Relationship (Type, Prin	19b. Ma	iling Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip	Code) 2/05
2	and lealth m 27 her tr		1000 morgan	150N 220	4 HUTUMN	Glow C	T. Belti	LIM CIOD
5	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	cometant co	position (Name of rematory or other place)	Date 20	c. Location - City or To	own, State
	t. Pa rtmen rtant: njury		*4 □ Donation 5 □ Other (Specify)	Dulaneyk	illey memoral ! Ilay	10,2005 1	moniom	rnD
<u>0</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. The proportent: If tem 27 is marked other than "natural; or them 23a or 28a-f show any injury or other traumatic event, the Medical Exam set must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility 88	300 Harfa	ord RD.	201
			23a. Part 1. Enter the disease, or complications		charel ro	or respiratory arrest	mDal	Approximate
١.	Dharatatan '		shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.	MER'S DEME			Interval Between Onset and Death
ľ	Physician /Medical		disease or condition resulting in death)	ue to (or as a consequence of):	Mer 2 Deme	HILL		
	Examiner							
	p ≅	ner	if any, leading to immediate D	ue to (or as a consequence of):				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c.					
oc,	rcate be executed physician and s the burial-transit	Ê	b	ue to (or as a consequence of):				
00/00	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dlcal	d					
X O	certif nding use a	√Me		s, outcome of pregnancy			23d. Date of delive	env
ă	death a atter	Physician/M	in the nest 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
5	t the by the tache	hys	9 ☐ Unknown 9☐	Unknown				
, L	es tha gned be de	ру Р	Part II. Other significant conditions contributing	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?
colds,	equir sen si ould					1 ☐ Yes	2-No 3□ Prob	oably 4 Unknown
2	law las be	Completed				24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
	: The	Con				performed 1 ☐ Yes 2 🗷	d2 death? No 1 ☐ Yes	
3	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:			th (Check only one)		
5	Phys this ral dir	To.	1 1 105 2 NO	1 ☐ Inpatient 2 ☐ ER/Outpati Date of Injury 28b. Time		ome of Residence	e 6 Other (Specif	(y)
5	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year) Injury		Edd. Describe flow	injury occurred	
0	Atten r deal sctor	ifica	3 Suicide 6 Could not be 28e.	Place of Injury - At home, farm, s		28f. Location (Stree	et and Number or Rura	al Route Number,
5	s afte	Certification;	4 Homicide	building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, and the Tothe Functal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier Certifying Physician: 2 Medical Examiner: On	To the best of my knowledge, det	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus	se(s) and manner as s	tated.
	the I	Medi	and	manner stated.				
	S T Will		29b. Signature and title of certifier	· · · · · ·	29c. License number	29d.	Date signed (Month,	Day, Year)
	4		30. Name and address of severe who severalists	traumo of doub (line 22a) 77	10950 JO	m	1, 06, 2	006
6)		Rame and address of person who completed the Review R.	n. 5601 (1811 234) (1900	TUENDRIVA SUITE	108-79 BA	AlTimone V	2021279
ľ	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	D36846 D36846 AVENTIVO Suites			(
	Registr	ar	MAY 1 0 2005	Sull St. 19				

			1 - State of Maryland /	Departme Certifica			ind Me		ene	5	15703
			Decedent's Name (First, Middle, Last)				2	. Date of Death			3. Time of Death
	Physicia /Medic		Patricia Mae McLaughli					May 8,	2005	ear	2:04 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		ity, Town, or				4c. County of		
			Frederick Villa Nursing Cer 5. Social Security Number 6. Sex 7. Age (In yrs. last b.		Cato der 1 Year	nsvi If Under 2		Date of Birth	Balt		
	Funeral Director		216-28-5263 1 M 2 M F 7. Age (mys. asi b)	Yrs. Month		Hours	Min.	Date of Birth (Month, Day, OCT 10,	1933	Coun Mox	lace (State or Foreign
			Usual Residence of Decedent					<i>x</i> 1 10,	1933	rial	cyland
	yland			wn or Location						10	Od. Inside City Limits
	e-f s	ctor	Maryland N/A		Balt	imore	j				1 Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number		Zip Code			10	g. Citizen of Wh	at Coun	try?
	23a	ral	507 Brisbane Road		21229				USA		
	tems	nne	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Yes 2 M No	13. Was De If Yes, s	cedent of Hi pecify Cuba	ispanic Orig n, Mexican,	in? (Specit Puerto Ric	y Yes or No- can, etc.)	14. Race - Black,	America White, e	
30	s afte	by F	1 □ Never Married 2 Married 1 □ Yes 2 Mo If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes	2 📉 No	Specify:			Specify:	W	hite
215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or Items 23a or 28e-f show the Medical Examicut must be motified at	edt		a. Decedent's U	sual Occupa	ation		111	5b. Kind of Busin	ness/Ind	fuetn
5	n"ng	plet	(Specify only highest grade completed)	(Give kind of life. DO NOT	work done d Luse retired,	during most	of working	''	DD. 14110 OF DUSI	1033/1110	ustry
7	be filed within 72 hours after deeth with the Marylan Ital Hygjene. Id other than "naturel", or Items 23a or 28e-f show event, Ite Medical Exactiver must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Buyer'	s Ass	istan	t		Drug S	tore	į
9	e file al Hy oth	Be C	17. Father's Name (First, Middle, Last)					First, Middle, Ma	aiden Sumame)		
<u>a</u>	Ment Ment arked	To	Bernard Frederick Amelong					Marie S			
Maryland	Pages 1 and 2 should be filed wit lent of Health and Mental Hygiend nt: If Item 27 is marked other thu ry or other treumatic event, Ite			b. Mailing Addre							Code)
ള ത്	l and lealth m 27 her tr		The state of the s	507 Bris		Road			MD 2122		
Ö	Pages 1 nent of H nnt: If ite try or ot		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ery, crematory o	or other place		Dat		Oc. Location - Ci	-	
Baltimore,	F 60 3		*4 □ Donation 5 □ Other (Specify) LOUGO 21. Signature of Funeral Service Licensee	n Park			5/12,	/05]	Baltimon	æ, I	MD
g	permit. Departrimportrimports any injudence.		Alward A. Combe	MacNa	and Addres	neral	Home	, P.A.			
			Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do		reder				ille, M	D 21	1228 Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final					oop.ratory arros	.,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	ome	NII	9				-	
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õ ×	eath certific: attending pl I for use as t	Med	IF FEMALE:							1	
XOP ROX		lan	23b. Was decedent pregnant in the past 12 months?						23d. Date of Month		ry Day Year
o.	D 0 0	Physician/Med	1 Yes 2 Do 4 Pregnant at time of death	5 🗆 Other ((ѕреспу)						
<u>,</u>	requires that the death neen signed by the atter hould be detached for t		Part II. Other significent conditions contributing to death but not resulting	in the underlying	g cause give	n in Part I.		23e. Did toba	cco use contribi	ute to the	e cause of death?
rds,	quires n sign	d by	failure To This	re				1 ☐ Yes	2 No 3	☐ Proba	ably 4 Unknown
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VItal	Iclen: Th certificate rector, pag	e C	25. Was case referred to medical			26 Place	of Death ((1 Yes 2 Check only one	2 No 1 □	Yes :	2 No
		OB	examiner? 1 Yes 2 WNo Hospital: 1 Inpatient 2 ER/O	Outpatient 3	DOA Othe	1			ce 6 Other	(Specify)
ס ר	iding Physin. In.: After this funeral di	n: T	(Alanth Bay Vac)	Time of Injury	28c. Injury Work	at	_		injury occurred		
000	Attending ir death. ector: After by the fune	atlc	2 Accident investigation	М		/es 2□N	lo				
DIVISION	of or Attency efter death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, fact	ory, office		28f	Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
	spitel ours el	Ce					- 1				<u> </u>
	To the Hospitel or A within 24 hours efter You the Funeral Director Completely filled in b.	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination at and manner stated.	nd/or investigati	ed at the tim on, in my op	e, date and pinion, death	place, and h occurred	due to the cau at the time, date	se(s) and mann e and place, and	ar as sta due to	the cause(s)
	Fo the	Me	29b. Signature and title of certifier	2	29c. License	number		290	I. Date signed (I	Month, E	Day, Year)
	11		Kternander Alten	dine	D	503	23		May 9,	20	05
(01		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		_	Α	UR			- 0
	W.		31. Date filed (Month, Day, Year) 32. Registrar's Signature	10 4	105	tre	don	UR	d	217	228
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2005	parke							

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 9, Helen Elizabeth Meany 2005 2:30a [™] /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health & Rehab. Center Edgewater Anne Arundel 8. Date of Birth MAY 23, 1914 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) DISTRICT of Columbia **Funeral** Days Months Hours 1□M 💥 F 90 578-07-1268 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Edgewater 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 144 Washington Road 21037 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 □ Divorced White Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Printing and Mailing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked other Ohio Delancey Boyle Ida Marion Reckeweg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline A. Mathwich/daughter P.O. Box 96 Church Hill, MD 21623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State permit. Page Department o Important: If any njury or injury or Metro Crematory, Incl. 5/9/05 Baltimore, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Transport of Dawn F. McDonald 22 Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia. Physician /Medical Examiner Cardiovasailan dispass Atheroscienotic Sequentially list co. luttons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ osteomyeliti 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24a. vvas an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Certification; To ihis 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 285. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Surana igun 5-9-2005 50653 GYAN.C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale Churchton Road. 31. Date filed (Month, Day, Year) MAY 1 0 2005 32 Registrar's Signature Registrar

			1- State of Maryland / Department of F State of Maryland / Department of F Certificate of R		lental Hygie	4000	15705
Г	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Catherine A. Mummert	.1	Moy (06 2005	
	Examin	er	77 * 36 * 4 77 * 4	r Location of Death 1timore		4c. County of Dea	ath
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Ri	rthplace (State or Foreign
	Director			Hours Min.	Mar. 31,	1909 Ma	ryland
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary Iled	tor	Maryland N/A Baltimore				1 XX Yes 2 □ No
	th the	Director	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What C	country?
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "neturel", or Items 23a or 28a-f show event, I're Mardinal Examinativities indiffed at			211		USA	
_	Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
20	el', or	by	If Yes, Give 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes	Specify:		Specify:	White
12-003e	within 72 hours after ene. then "neturel", or Ite he Wedfaal Examina	Completed	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done	during most of work	16i	o. Kind of Business	s/Industry
7	within ane. than	mp	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	1)		0 1	T
D	e filed within al Hygiene. I other than '	a)	17. Father's Name (First, Middle, Last)	18. Mother's Nam-	e (First, Middle, Mai	Own I	lome
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Mar	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked eny injury or other treumatic e once.	•	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street:	and Number or Run	a <i>l R</i> oute Number, C	ity or Town, State,	Zip Code)21204
a,	1 and Health em 27 ther tr		Alan Stocksdale Attorney 305 West I			e, Towson	n, Maryland
JOE L	ages ant of little it. If its		1XXBurial 2 Cremation 3 Removal from State 4 Donatjon 5 Other (Specify) Truid Ridge Cemeter	ce)			Maryland
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			23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dyin shock, of heart failure. List only one cause on each line.	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
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Ţ.	that the	۵,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I	23e. Did tobac	co use contribute t	o the cause of death?
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ecords	aw is b	pleted			24a. Was an	24b. Were a	utopsy findings available
~	0 - 0	Com			autopsy performed 1 ☐ Yes 2 ☑	death?	completion of cause of
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	phys this al di	: To	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Cthe 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	4 🗆 INDISHING FIO	me 5 Residence		ecify)
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	To t To t	Σ	29b. Signature and title of certifier 29c. License			Date signed (Moni	
	h			47044	6 010 m	04,00,	200.J
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manso Mohehtash, 20) F. University 0	KINI R	altimace	NAN (11015
	" Sta		Manso Monestash, 201 E. University P. 31. Date filed (Month, Day, Year) MAY 1 0 2005 MAY 1 0 2005	1-201	W. HINDIE	4 1-113	(1010
	Registr	ar	MAY I U CUUS PERSON NO 1				

			For State Registrar	State of Maryland		artment of H artificate of L			giene Reg. No.	05	15706
			Decedent's Name (First, Middle, Last	St.) or wind and a state of the				2. Date of De		Year	3. Time of Death
	Physicia /Medic	al .	Phillip D	Morpon				OS		2/02	- 0225M
	Examin		4a. Facility Name (If not institution, give	e street and number) DCK MULLET		4b. City, Town, or			4c. C	ounty of Deal	th
	Funeral		5. Social Security Number 6. S		st birthday	If Under 1 Year) MORS_ If Under 24 Hrs.	8. Date of Birt	h	9. Bin	thplace (State or Foreign
	Director			ØM 2□F	Yrs.	Months Days	Hours Min.	(Month, Da 11-8-	1958	Co	MD MD
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or L	ocation					10d. Inside City Limits
	Maryli f sho	ō			BALTI						1. Yes 2 □ No
	r 28a	Director	MD 10e. Street and Number		'VULLE	10f. Zip Code			10g. Citize	n of What Co	ountry?
	th wit	alD	700 VINE STREET			2120				USA	
	er dea itams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14	. Race - Ame Black, Whit	
39	Irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		S	pecify: BI	LACK
5-0036	72 hours after death with the Maryland Instural', or Items 23a or 28a-f show Jigal Examilian must be motified at	ted	15. Decedent's E. (Specify only highest gra	ducation	16a. Deci	edent's Usual Occupa	ation	dina .	16b. Kind	of Business	/Industry
2121	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	3	1731	TOPD I	AND TIMES
	filed v Hygle thar t		17. Father's Name (First, Middle, Last)			TRUCK DRIV	18. Mother's Nam	e (First, Middle,			AN LINES
<u>a</u>	lid be kad o ic eve	То Ве	RAYMOND LEE MORT				MURIE	E. PIN	DER		
Maryland	s mar		19a. Informant's Name/Relationship (**		ling Address (Street a					<u></u>
	and 2 ealth m 27		TOMECA MORTON/NI			2 PALMER A		BALTIMOR Date			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examination and any injury or other traumatic event, the Madical Examination and any injury.		20a. Method of Disposition Disposition 3 □ Cremation 3 □	Removal from State	metery, cre	ematory`or other plac	θ)		_	ition · City or	
Ħ	artme ortant injury		'4 □Donation 5 □ Other (Specification of Funeral Service Licer		ing	Mem PK. 22. Name and Addres	is of Facility JA	3-05 MES A.	MORTO	N & SC	ONS F.H., INC.
ã	Depariment of the part of the		James C	i. Morten		1701-31 L					YLAND 21217
			23a. Parts. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	4 1	Immediate Cause (Final disease or condition resulting in death)	a_ Parce	14	15					Oliset and Death
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68760,	ificate g phys as the	edicai		d							
Вох	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal		Ectopic pregnancy			23	d. Date of de Month	livery Day Year
о П	that the death cer ed by the attendir detached for use	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea	ath 5	Other (specify)				MONUT	Day
P.O.	that the	y Ph	Part II. Other significant conditions	contributing to death but not resul	ting in the	underlying cause give	en in Part I.	23e. Did t	obacco use	contribute to	o the cause of death?
rds	w requires been signe should be	ed by						1 🗆 '	Yes 2 🗹	No 3□P	robably 4 Unknown
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Ē E	The page	Com						perfo	2 No	death?	2 □ No
Vita	iclan: certific	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea				
o	Attanding Physician: or death. actor: After this certifics by the funeral director, I	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death		R/Outpation 28b. Time	of 28c. Injury	4 Nursing H	ome 5 Resident			icity)
ion	anding ath. or: Afte	atio	1 Matural 5 ☐ Pending investigation	n	Injury		Yes 2 □No				
Division of Vital Records,	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, s	street, factory, office		28f. Location (, City or Tox		Number or R	ural Route Number,
	To the Hospital or within 24 hours after To the Funaral Diracompletely filled in b		29a. Certifier Certifying Pl	nysician: To the best of my know	rledge, dea	ath occurred at the time	ne, date and place	, and due to the	cause(s) a	nd manner as	s stated.
	ne Hos n 24 h ha Fur oletely	edical	(Check only 2 Medical Ever	miner: On the bacic of examinati	on and/or	invectigation in my or	ninian death accu	rrad at the time	date and a	lace, and due	
	To the comp	M	29b. Signature and Ittle of certifier			29c. Licenso	e number	()2	29d. Date	signed (Moni	th, Day, Year)
	100			and along the state of the stat	00=1 (**	AU 4	1 MC(101)	ONS	5	12/03	
L	7'		30. Name and addiss of person who	A A A O I a I A I .	23a) (Type	, May	MD SH	OCKN	Ail	ut.	
	Sta		31. Date filed (Month, Day, Year)	32. Registra s Signati	ure #	hade					
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NJM 05-03004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	o-03004 erman M		TS For 1 — State Registrar	State of Ma	ryland				ealth a			giene Reg. No.	2005	5 1	5707
Е	Obverior		1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath Day	Yea	3. Ti	me of Death
	Physicia /Medic		Herman A	llen	My	ers				*	April	30			335 M
	Examin		4a. Facility Name (If not institution, g				4b. City	Town, or	Location of	of Death	1	4c.	County of D	eath	
			1176 Cleveland					ltim				Ва	ltimo	re Cit	у
	Funeral		5. Social Security Number 6.	Sex 7. Age 1 1		ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	Min	8. Date of Bird (Month, Da	h y, Year)		Country)	tate or Foreign
	Director		371 40 7232		83	Yrs.					July 6,	1921		Virgin	ia
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Insi	ide City Limits
	Aaryl sho	ō	Maryland		В	altimo	ore (ity						1 🗆	X es 2 □ No
	28a-	Director	10e. Street and Number				10f. Z	p Code			Т	10a. Citi	zen of What	Country?	
	with Ba or	흐	1176 Cleveland S	treet					1230			-		State	ı Ç
	death with the Maryland ms 23a or 28a-f show	Funeral	11. Marital Status	12. Was Decedent E	ever in U.	S. 13.	Was Dece			igin? (Spe	ecify Yes or No Rican, etc.)		14. Race - A	merican Indi	
	r iter	F	1 XNever Married 2 Married	Armed Forces? 1 X Yes 2 □ N	lo TH	1					Rican, etc.)		Black, W		
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WW	II	1 ∐ Yes	2 M No	Specify:				Specify:	wnite	
3-003p	filed within 72 hours after Hygiene. other than "natural", or Ite ant, the Medical Exactina	Completed	15. Decedent's (Specify only highest of			16a. Dece (Give life.	dent's Usu	al Occupa	ation	t of work	ina	16b. Kir	nd of Busine	ss/Industry	
N	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	+>	life.	DO NOT	ise retired)		9				
7	e filed within Il Hygiene. other than " vent, Ine Me	Con	12			L	ieute	nant						tates	Navy
2		Be	17. Father's Name (First, Middle, La								e (First, Middle,	Maiden	Sumame)		
ryland		ပ	Pelham Leonard		٠.				Laur		lder				
<u>ro</u>	C1 00 -50 65		19a. Informant's Name/Relationship Jacqueline M. Lu								al Route Numbe a msbur g				5
	D - C -			sk, niece	1001 5				ve, w						
ore	© ° = ≥		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐Removal from State	Ce	lace of Dispo emetery, crei	matory`or	other plac			Date			or Town, Sta	
Ē	Pag ment ant: ury c		* 4 ☐ Donation 5 ☐ Other (Spe	cify)	Riv						0, 2005				1
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Fund Saylog is		01113						en Funera te G, Gla				
	Physician and /Medical Examiner use as the private transit	Ical Examiner	shock, or heart faflure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequ	uence of): uence of):	i (1200	2010	cuin	N 0 13E	à se		Onset	al Between and Death
õ	rtifica ng ph as th	ed	IE EEMALE.												
O. Box	death e atter	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	⊒Ectopic ⊒ Other (s	oregnancy specify)				2	23d. Date of Month	delivery Day	Year
J.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death by	ut not resi	alting in the u	ınderivina	cause divi	en in Part I	I.	23e. Did t	obacco u	se contribut	to the caus	e of death?
Š,	signe signe d be	1 by					, ,				1 🗆	Yes 2	⊇ ‱ 3□	Probably	4 Unknown
ecords,	w require been sign	Completed									04- 146-		045 144		dia a a constabile
%ec	The law ate has I	ldu									24a. Was autop		prior death	to completion	dings available n of cause of
<u> </u>	: The cate h:	ပိ									1 Yes	2℃No		es 2 No	0
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or.		h (Check only o				
	Phys this al dir	은	Yes 2 No	1 Inpatie		ER/Outpatie 28b. Time o		UA	4 LINI		me 5 Resi			pecify) SC6	ene
Ü	ding l h. After funer	o	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	y Year)	Injury	" м	28c. Injun Worl	k? Yes 2 🗍		200. Describe	now injury	y occurred		
Division of	deatl deatl ctor; the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be 290 Place of Inju	ury - At ho	ome, farm, st.			163 2		28f. Location (City or To			Rural Route	Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical C		Physician: To the best of aminer: On the basis of and manner sta	fexamina										use(s)
	o the	Me	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Date	e signed (M	onth, Day, Ye	ear)
	F ≥ F 5		> W D 11 - 1	Mac Marco	44-0			00	CME			14	4	0005	
	11		30. Name and address of person wi	in completed cause of d	eath (Item	23a) (Type	Print\	U	بالاي			May	/ , 1,	2005_	
	M		MAYUD OUTS A.	KURELL	oatti (itali	. 202/ (Type,		1 Per	nn St	reet	Baltim	ore	Marvla	and 21	201
	Sta	to	31. Date filed (Month, Day, Year)	2. Registra	ar's Signa	ture /								21.	
	Regist		MAY 1 0 20	15 Same	15.	A co	and I								

DHMH 17 Rev 1/2001

				State of Maryland / Department of Health and M State Registrar State of Maryland / Department of Health and M Certificate of Death		ene () ()	5 15708
		Physicia	an	1. Decedent's Name (First, Middle, Last) Bertha E. Middleton	2. Date of Death Month		Year 11,25 PM
		/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	llay	4c. County	
		Examin	er	North Arundel Hospital Glen Burnie			Arundel
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
		Director		218 14 8029 86 Yrs.	Feb. 6,	1919	Maryland
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
نلا		Many Many	tor	Maryland Anne Arundel Glen Burnie			1 ☐ Yes 2 🔀 No
લ		or 28	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of W	
关		death with the Maryland ims 23a or 28e-f show ir must be notified at		7851 Crilley Road Apt. 508 21060 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	acifu Vas or No-	U.S.	e - American Indian,
Bert	(0	r Itam	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
Œ,	903	72 hours after natural', or Ita	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:			: White
5	15-(n 72 h "natu edice	lete	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Bu	siness/Industry
to	212	i within jiene. r than "	Completed by Funeral	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	(Own Hom	ie
7	pu	al Hyg	Bec		e (First, Middle, M		Θ)
Riddleton	yla	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic evant, It a Me	2		E. Norfo		0.1.7.0.11
Z_{γ}	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural; or Itams 23a or 28e-f show any injury or other traumatic evant, the Medical Examinat must be inclified at once.	1	19a. Informant's Name/Relationship (Type, Print) Elaine Herman 19b. Mailing Address (Street and Number or Rura 327 — 6th Avenue		-	state, 215 Code) Syland 21225
		s 1 an f Heal itam 2 other		cometeny crematony or other place)	Date 2	0c. Location -	City or Town, State
	E C	Page nent o ant: If ary or		A Donation 5 Other (Specify) Holy Cross Cemetery 5/7/2			re, Maryland
	Baltimore,	permit. Departr Imports any inju		21. Signifure of Funeral Service-Licensee 22. Name and Address of Facility G			,
		₹0 = @ ol		234. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac			Maryland 21225 Approximate
_		Dhamisian		shock, or heart failure. List only one cause on each line.	or roophatory arros		Interval Between Onset and Death
		Physician /Medical		resulting in death)	-		
		Examiner		Sequentially list conditions. b. Congestive Heart Failure			
		ed sit	Examiner	Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Chronic Obstructive Pulmonery	Diseas	2	
3	×	al-trar	xan	that initiated events resulting in death) Last Due to (or as a consequence of):			
	8760	ate be executed hysician and the burial-transit	cail	d			
	89	ing ph	Medi	IF FEMALE:			
	Box 68	eath certifics attending ph for use as t	Physician/Medicai	23b. Was decedent pregnant in the past 12 mg/ths?		23d. Date Mor	e of delivery nth Day Year
	P.O.	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ②Mo 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
	ds, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the cause of death?
	Division of Vital Records,	aw requas been 2 shoult	Completed		24a. Was an	24b. V	Vere autopsy findings available
	Re	The lavate has	omi		autopsy perform	ed?/ d	orior to completion of cause of death?
	/ita	ysician: Th is certificate director, pag	Be	evaminer?	h (Check only one)	
	of	Physi this c	2	The state of the s	ome 5 Resider		
	O	tanding Ph leath. tor: After th the funeral	tion	27. Mann of Death 1 Vatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 No			
	N.	el or Attandir after death. I Director: Af d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,		er or Rural Route Number,
	ā	oitel or ors after ral Di	Cer				
		To the Hospitel or Ai within 24 hours after or To the Funeral Direct completely filled in by	ledicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
		To the within 2 To the complet	Me.	29b. Signature and title of certifier 2 2 29c. License number			(Month, Day, Year)
		,		Deorge C. Wills II M.D. D41365	1	lay 4	, 2005
_		X		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) to Drive, George E. Wilks M.D. 301 Kilspitei Drive, G	Hen Bi	ivnie	MD. 21061
		Sta Registi		31. Date filed (Month, Day, Year) MAY 1 0 2005 32. Registry's Signature			

	· · · · · · · · · · · · · · · · · · ·	ate of Death	Reg	. No.	10102
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Gary Wayne Mitchell, J	Ir.	2. Date of Death Month	Day Year	3. Time of Death
/Medical		City, Town, or Location of Death	7	005 4c. County of Death	12:01 P M
Examiner		rkville		Baltimore	
uneral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	nder 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo		place (State or Foreign
ector	Usual Residence of Decedent	ths Days Hours Min.	Dec. 10,		ryland
ied at	10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore			1	10d. Inside City Limits 11 Yes 2 □ No
ust be nutified at ral Director		. Zip Code 21225	10g	. Citîzen of What Cour U.S.	ntry?
riner must Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D Armed Forces? 13. Was D If Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
ρ	1 Never Married 2 Married 1 Yes 2 No	s 2 No Specify:	Triball, 6(0.)	Specify: Whit	
leted	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind)	Usual Occupation f work done during most of work IT use retired)	king 16	b. Kind of Business/In	dustry
vent, the Medical Exp 3e Completed by	Elementary/Secondary (0-12) College (1-4or 5+) Roofer	ri use retirea)		oofing	
atic event, the Medical I	17. Father's Name (First, Middle, Last) Gary Wayne Mitchell Sr.		e (First, Middle, Mai a Hynes	iden Sumame)	
eumatic eve		ress (Street and Number or Ru			· ·
other tre				Maryland 21	
injury or other treumatic	20a. Method of Disposition 1	(Name of or other place) Mem. Park 5/12	110	c. Location - City or To Len Burnie	
eny injury or of	(8/11)	e and Address of Facility G			
the burial-transit the burial-transit and points if cal Examiner	23a. Part. Enter the disease, or complications that caced the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate that the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	•			Approximate Interval Between Onset and Death
etached for use as the PhysIcian/Medic		ic pregnancy r (specify)		23d. Date of delive Month	ery Day Year
p p	Part II. Dther significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?
page 2 should t			24a. Was an autopsy performer	prior to co	opsy findings available impletion of cause of
8 g	25. Was case referred to medical	26. Place of Dea	th (Check only one)	7140 7123	2010
E S E	examiner? 1 Xes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3		ome 5 Residenc	e 6 x ther (Specif	scene
्र प		28c. Injury at	28d. Describe how		TRAILER
his o	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work?	DOLLAND Kings	we stewer	7 12/2/20710
돌	27. Manner of Death 1 Natural 2 Accident	1 ☐ Yes 2 ☑ No	PRINCE OF TY		
Director: After this in by the funeral d rtification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 4 No Solution 28b. Place of Injury - At home, farm, street, fa building, etc. (Specify)	1 ☐ Yes 2 ☑ No Victory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
Director: After this in by the funeral d rtification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only Check only 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, street, fa building, etc. (Specify)	1 □ Yes 2 ☑ No Victory, office	28f. Location (Stree City or Town, S OWE LILLI and due to the caus	et and Number or Rura State) DIV HOLT DR-B se(s) and manner as s	al Route Number, Dunopes a Mi tated.
Director: After this in by the funeral d	27. Manner of Death 1	1 □ Yes 2 ☑ No Victory, office	28f. Location (Stree City or Town, S OWE LILLI and due to the caus rred at the time, date	et and Number or Rura State) DIV HOLT DR-B se(s) and manner as s	al Route Number, Dunney Scuriff tated. the cause(s)
To the Funerel Director: After this completely filled in by the funeral d Medical Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time	1 ☐ Yes 2 ☑ No Victory, office rred at the time, date and place, tion, in my opinion, death occur	28f. Location (Street City or Town, \$ 600000000000000000000000000000000000	et and Number or Rura State) DIV HOUT DR-B se(s) and manner as s and place, and due to	al Route Number, Dunney Scuriff tated. the cause(s)
ne Funerel Director: After this oletely filled in by the funeral d edical Certification; To	27. Manner of Death 1	1 ☐ Yes 2 ☑ No 1 Ctory, office rred at the time, date and place, tion, in my opinion, death occur 29c. License number	28f. Location (Street City or Town, \$ 600000000000000000000000000000000000	et and Number or Rura State) DI UST DR-B se(s) and manner as s and place, and due to Date signed (Month, V 8, 2005	al Route Number, Durnoyes as Migrated, tated, the cause(s) Day, Year)

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 58 **Physician** ared /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death, 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1□M 2 F Months -26-256 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a., State 10c. City, Town or Location i Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23a or 28a-1 shov other traumatic event, the Medical Evantinal must be rediffed at 1 Yes 2 □ No Completed by Funeral Director MORR 10f. Zip Code 10g., Citizen of What Country 10e. Street and Number 130 United Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give / Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: LACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry C1roary College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. lerk 10 17. Father's Name (First, Middle, Last 18: Mother's Name (First, Middle-Maiden Surname) Be UCILIA 19b. Mailing Ad Less (Street and Number or Rural Route Number, City or Town, State, Informant's Name/Relationship (Type, Print) Kandallstown Moore Antler Circle Baltimore, 20b. Place of Disposition (Name of gemetery, crematory or other, place) Date 20c, Location - City or Town, State 20a. Method of Disposition May Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Ceneferi 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens errice, uneral marl, BAIN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner 251 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Heart The law requires that the death certificate be executed true Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 wonths?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Pact II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part, 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes or Attending Physician: After this certification, I 25. Was case referred to medical 26. Place of Death (Check only orfe) Be Hospital: 1 Inpatient 2 ☐ EP/Outpatient 2 No ٩ 1 🗌 Yes 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 2 Accident death. 1 Tes 2 No filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tine of certifier ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Pay 32. gistrar's Signature State Registrar

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			1 - For State Registrar	State of Maryland / I	-	ent of Heate of L			giene	15	1571
	Physic	an	Decedent's Name (First, Middle, Last) JEAN MILES					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. (City, Town, or	Location of Dea	MAY 6,		ty of Death	6:15a M
			3436 ROUND RD.			BALTIMO		. (N/.		
H	Funeral Director		5. Social Security Number 6. Security Number 10. Security Number 1	THE OFFICE	Yrs. Mon	nder 1 Year ths Days	If Under 24 Hr Hours Mir		h y, Year) 930	9. Birthi Cou MARY	place (State or Foreign ntry) LAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location						10d. Inside City Limits
	the Marylar 28a-f show	tor	MD. N/A		TIMORE						1 X Yes 2 ☐ No
	or 288	Director	10e. Street and Number		10f	. Zip Code			10g. Citizen of	What Cou	ntry?
	s 23e	erai [3436 ROUND RD.	10 Was Deceded Free 5 H C	140.144 - 5	21225			USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then the marked other than "neturel", or Items 23e or 28e-f show other traumatic event, the Marical Exercities must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	1	ecedent of His specify Cubar es XIX No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Speci	ace - Americack, White,	
2-0(72 hou	eted	15. Decedent's Edu (Specify only highest grade	cation 16a.	Decedent's	Usual Occupa	tion uring most of w	ndkina	16b. Kind of E	Business/In	dustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired) EMPLO	-		DAMO	A D E	
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		SELF			ame (First, Middle,	DAYCA Maiden Suma		
ylar	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ite M.	To B	GEORGE MULLEN				OLLI	E COATES			
Maryland	and 2 sho salth and n 27 Is ma		19a. Informant's Name/Relationship (Ty) MICHELE LEWIS (I					Rural Route Numbe IMORE, MA			
ore,	of Health of Health fitem 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☑ Femation 3 □ R	20b. Place of	f Disposition			Date	20c. Location		
altimore,	Department of Pages Department of Importent: If its Importent: If its Iny injury or of		* 4 ☐ Donation 5 ☐ other (Specify)	CEDAR		CEMETER		2-2005	GLEN BU	JRNIE	, MARYLAND
Bal	permit. Pa Departmer Importent any injury		21. Signature of Fun al Servin License	Hibren .	172	L-27 N.	MONRO	E ST. BAL	TIMORE		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Gause (Final disease or condition resulting in death)	cations that caused the death. Do no cause on each line. Mutautat Due to (or as a consequence	c he	ung	Can C		rest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
O. Box 6	The law requires that the death certificate tie has been signed by the attending phy. age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 rymiths? 1 □ Yes 2 ₩ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectop 5 □ Other	ic pregnancy (specify)				ate of delive	ory Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlyin	ng cause giver	n in Part I.	23e. Did to	/		ne cause of death?
Records,	The law requir ate has been si page 2 should l	Completed						24a. Whas a autops perfor	med?	Were auto prior to cor death? 1 \(\subseteq \text{Yes} \)	psy findings available mpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					eath (Check only or			
of	Phys r this rat dia	. To	1 ☐ Yes 2 ② No	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou 28a. Date of Injury 28b. 1	tpatient 3	DOA Other	4 🗀 Nursing	Home 5 Residence 128d. Describe he			y)
ion	Attending F death. ctor: After y the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		njury M	Work	es 2 No	250. 5000 10	ow many occur	100	
Division	al or Attend s after death bl Director: ,	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, fac	ctory, office		28f. Location (S. City or Town		ber or Rura	I Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ilcian: To the best of my knowledge ner: On the basis of examination an and manner stated.	, death occur d/or investiga	red at the time tion, in my opi	o, date and place nion, death occ	e, and due to the c urred at the time, d	ause(s) and malate and place,	anner as st and due to	ated. the cause(s)
	To t withi To tl	×	29b. Signature and title of certifier Mulm	5		29c. License		2	29d. Date signe	id (Month,	Day, Year)
•	3	1	30. Name and address of person who co	+ 0 . mpleted cause of death (Item 23a) (2 300 5 . H d	(Type, Print)	p Ct	Bri 1	timore	5/1	710	5
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	MUVE	72 31.	bul	MINOU	יווע	4	us .
	Registr	-	MAY 1 0 200	32 Registrar's Signature	Goods	3					

			1 - State C		artment of Health and Natificate of Death	nental Hygier Reg. I	2000	15712
	Σ,		Decedent's Name (First, Middle, Last)		•	2. Date of Death		3. Time of Death
	Physici		Monique B NorD	PEN		Month 1	Day Year 7,005	12 300 M
	/Medic Examin		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Death	
			Howard County General H	lospital	Columbia		Howard	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year if Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl Coun	ace (State or Foreign
	Director		110-42-0326 1□M 2₺ F	76 Yrs.	William Buys Frodis Hills.		1929 Franc	
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	antion		14	Od. Inside City Limits
	shov	_	Maryland Howard		mbia		10	1 ☐ Yes 2 Ž No
	the Marylan 28a-f show	ecto	10e. Street and Number	0010				
	with a or ;	Funeral Director			10f. Zip Code	_	Citizen of What Coun	try ?
	eath	erai	7070 Cradlerock Way	edent Ever in U.S. 13.1	Vas Decedest of Hispania Origin? (Sr		14. Race - America	no lodiao
	lter d	'n.	11. Marital Status 12. Was Dec Armed Fo 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	orces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Gir	ve "	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or llems 23a or 28a-f show he Madical Examinational to multibut at	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Ind	
215	hin 7	ed d	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ang		
2	ad will	Son	6		ptionist		Government	
pu	be filed Ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maid	len Sumame)	
Maryland	ges 1 and 2 should be filed within 72 hours atter death with the Maryla, to Heath and Mental Hygiene. It id Heath and Mental Hygiene. It item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Expiriting outside the colline at	2	Marcel Henri Ernest Ver	dier	Alice	Renee Gaud	ard	
lar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rui			· ·
	1 and 2 Health Iem 27 (Peter Nordeen (Husband	<u> </u>	Cradlerock Way C			
ore	Pages 1 nent of H int: It ite iry or ott		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from	State 20b. Place of Dispo	natory or other place)	Date 20c.	Location - City or To-	wn, State
Ë	tant:		* 4 □Donation 5 □ Other (Specify)			-2005 Lau	urel, Mary	land
Baltimore,	permit. Pages Department of Important: It i any injury or once.		21. Signature of Funeral Service Licensee	- Wi	t Name and Address of Facility tzke Funeral Home 55 Twin KNolls Ro	s, Inc.	oia. Marvl	and 21045
	ş.		23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on a	caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	, , , , , , , ,	Approximate Interval Between
	Physician		Immediate Cause (Final	custatic Lui	m Cancer			Onset and Death
	/Medical		resulting in death)	(or as a consequence of):	mg conce			O POPPLICATES
г	Examiner		Sequentially list conditions					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):				
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8760,	cian cian ourial	E	Due to	(or as a consequence or),				
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×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, our	tcome of pregnancy			22d Date of deliver	
Вох	atten for u	clan	in the past 12 months?	ointh 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
o.	the d y the iched	ıysi	1 ☐ Yes 2 MNo 9 ☐ Unknown 9 ☐ Unkn					
Δ.	that sed b deta		Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
Records,	quires n sign	d by				1 Yes	2 □ No 3 □ Proba	ably 4 □Unknown
O	w requir been si should	Completed				24a. Was an	24b. Were autor	sy findings available
Re	The lav	mc				autopsy performed?	prior to con death?	pletion of cause of
Vital	ician: Th	a	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 🔼 î h (Check only one)	No 1 □ Yes	2 No
>	99 S =	ToB	examiner?	Inpatient 2 ☐ ER/Outpatier	Other	ome 5 Residence	6 □Other (Specify	1
of			27. Manner of Death 28a. Date	of Injury 28b. Time of	28c. Injury at	28d. Describe how in		<u></u>
Division	ath. r: Att	atio	1 Natural 5 Pending (Mon 2 Accident investigation	th, Day Year) Injury	Work? M 1 □ Yes 2 □ No			
<u>Vis</u>	I or Attendi atter death. Director: A I in by the t	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place	of Injury - At home, farm, string, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	s atte	Certification:	Ballo	ing, stc. (opecity)		only or rown, on	110)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely tilled in by the fune	Medical	(Check only 2 Medical Examiner: On the b	e best of my knowledge, death asis of examination and/or in ner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	<i>a</i>	29c. License number	29d. [Date signed (Month, L	Day, Year)
			Y luber 12 det] nos	D38509	m.	443 20	05
	7		30. Name and address of person who completed cause	se of death (Item 23a) (Type,		0: 1		
1	Sta	to	30. Name and address of person who completed cause Picific MS Hourize lubbs 31. Date filed (Month, Day, Year) 32. F MAY 1 0 2	MD 1065 Ling	HIR PATULATION PIR.	Columbi	is MI)	21044
	Registr		MAY 1 0 2	805 Kleeve	D. Marie			

	1	_ State	partment of Health and I Pertificate of Death		ene 2005 15713			
to		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	f Death 3. Time of Death			
Physicia		ahua Plan	Σ,	May	J 2005 749 AM			
/Medica	-5	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		4c. County of Death			
Examine	er	Now Janost Hospital Center	Princhalls tour	N	Baltunger			
7. 5. 2.	1 .	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year if Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign			
Funeral Director	- 1	214-65-1353 ^{1⊠M 2□F} 61 Yrs	Months Davs Hours Min.	June 12,	(ear) Country) Vietnam			
	-	Usual Residence of Decedent		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
/land		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits			
Many -1 ah	ţ	MD Baltimore F	leisterstown		1 ☐ Yes 2X☐ No			
1 the	e l	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?			
3a o	0	308 High Knob Lane	21136		U.S.A.			
death with the Maryland ms 23a or 28e-f ahow rinual be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No-	14. Race - American Indian, Black, White, etc.			
or ite	큔	1 Never Married 2 1 Married 1 ☐ Yes 2 1 No	1 ☐ Yes 2 X No Specify:	o moun, 0.0.,	Specify:			
within 72 hours after ene. than "natural", or ite he Medical Explicits	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 163 2 2 2 110 Specify.		Asian			
72 hc	tec	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of wo	rking	6b. Kind of Business/Industry			
Page 6	pie	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)					
w gien	Completed	12	Carpenter	(5) 1 46 1 4 1 4	Carpentry			
na Z be filed al Hygie 1 other went.	Be (17. Father's Name (First, Middle, Last)		me (First, Middle, M				
Viand vuld be fit Mental H arked oth atic even	၉	Toan Phan			Nguyen			
Short and and and and and and and and and and		19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or Re	ıral Route Number,	City or Town, State, Zip Code)			
and and and and and and and and and and		Tien T. Nguyen Wife	308 High Knob Lane					
of He	1		isposition (Name of crematory or other place)		0c. Location - City or Town, State			
Pages nent of I	1	`4 □Donation 5 □Other (Specify) Carroll	Cremation Ser 5/8	/05	Hampstead, MD			
Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other transmiss.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	11824 Re	isterstown Road			
2 88 E 8 8		Jam B Okan	Eline Funeral Hom		erstown, MD 21136			
		23a. Part 1. Enter the disease, or somplications that caused the death. Do no shack, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arre				
Pnysician		Immediate Cause (Final	mair cardiou	Maila	Onset and Death			
/Medical		discrete or condition resulting in death) a. Due to (or as a consequence of)		asc a ra	G. Kest			
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	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
uted	Examine	Cause (Disease or injury that initiated events						
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8760, cate be executed by sician and the burial-transit	cal	d						
68 tificat as th	73							
Box 68 eath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant 1	3 Ectopic pregnancy		23d. Date of delivery			
Geath	icia	in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		Month Day Year			
P.O.	Physician/Me	9 Unknown						
E Y 7	by P	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		acco use contribute to the cause of death?			
rds quire nn sig uld b	pa p	Mypercholesterolemia		1	s 2 □ No 3 □ Probably 4 ☑ Unknown			
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Re ta ta ta ta ta ta ta ta ta ta ta ta ta	E			perform	ed? death?			
in: T		25. Was case referred to medical	26. Place of De	ath (Check only one				
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Of Phy grathis	. To	27 Manner Death 28a Date of Injury 28b. Tir	ne of 28c. Injury al	28d. Describe ho	w injury occurred			
On Iding Ith: Afte fund	ig ig	1 1 Tatural 5 □ Pending (Month, Day Year) Inj 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No					
Division of Vital Records, to Attending Physicien: The law requires I after death. Director: After this certificate has been signed in by the funeral director, page 2 should be come.	Certification:	3 Suicide 6 Could not be 28e Place of Injury - At home, farm	n, street, factory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)			
Diversity of the last of the l	ert	4 Homicide determined building, etc. (Specify)		ony or rown, state,				
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the ca	use(s) and manner as stated.			
e Ho 24 F e Fu	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occ	uneu at the time, da	ne and place, and due to the cause(s)			
To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	ed. Date signed (Month, Day, Year)			
		Vara Tall Held	(Wato 1) 00523	160 M	1ay 7,2005			
d	ļ	30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	1//	7			
2		Byol old Court Road	Randallstoron	MD 2	1133 ERICA TOBIN			
Sta	ate	31. Date filed (Month, Day, Year) 32. Ruistrar's Signature	Legali)	/	MULDROW,MB			
	rar	MAY 1 0 2005						

			1- State of Maryland / Department of Health and Mental Hygiene 15 57 1 Certificate of Death	ķ
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea	th
	Physici /Medic		JOSEPH RHTANES MAY 08, 2005 10:45 M	1 M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
			BON SECOUR HOSPITAL BALTIMORE 4TY NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fo.	reign
н	Director		219-60-2325 10M 20F 5/ Yrs. Months Days Hours Min. (Month, Day, Year) 100 MARILLAN	10
	P .		Usual Residence of Decedent	
	show	3	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	
	e W	cto	MARYLAND N/A BALTIMORE CITY KIYOS 2]No
	ith th	Oire	10e. Street and Number 10f. Zip Code 10g/Citizen of What Country?	
	23e	20	1506 MORELAND AVENUE 21216 USA.	
	r deg	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	or it			
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "neturel", or items 23e or 28e-1 show event, the Medical Examerations and the notified at	d by	3 Wildowed 4 Divorced Year or Dates:	
5	"net	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry	
12	within ene.	Ę.	Elementary/Secondary (0-12) College (1-4or 5+)	
	filed y Hygie other i			47764
ä	ild be filental hiked of	Be	Committee of the first, industry, made of surfacility	
Ĕ	ould to marked	2		
Maryland	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
_	1 and 2 Health em 27		HATSYRHYANES (WIFE) 1506 MORELAND AVE, BALTIMORE, MD. 2/2/	6
5	Pages 1 nent of H int: If ite		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
<u>=</u>	Pa nen ant:		· 4 Donation 5 Other (Specify) CENTREVILLE (EMP 25-12-25 CENTREVILLE M.D.	,
Baltimore,	permit. Pag Department Importent: any injury c once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2140 North Fulton Avenue 2/2/	7
ш	20 5 20		Letich N. Williams Joseph H. Brown, Jr. Funeral Home Baltimone	MI
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between	
	Prhysician		Immediate Cause (Final disease or condition resulting in death) a. (SWOESTIVE WEART FYICURE gnset and Death YEAR)	
	/Medical		resulting in death) Due to (or as a consequence of):	
	Examiner		AONTIC INSUPPLIENCY YMAN	
		iner	f any, leading to immediate Cause Fixed Indertying Due to (or as a consequence of):	
	cuted nd ransi	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events	
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9		ledi		
Вох	death certiff e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
m.	deat d for	in the past 12 months? 1 Vec 2 No. 4 Pregnant at time of death 5 Other (specify) Month Day Year		
0	that the death ed by the atter detached for	hys	9 Unknown 9 Unknown	
ر ب	requires that the een signed by th nould be detache	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
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00	w requir been si should	Completed	Steps Mobes Mela by S. C. Sestinus Did ale 24a, Was an 24b, Were autopsy findings availa	blo.
Re	The law I cate has b page 2 sh	mc	3) EED 17 PEL VIEW 5 IN SC 3 PEN SC 124a. Was an autopsy performed? 24b. Were autopsy findings availad prior to completion of cause of death?	of
a		e Co	1 Yes 2 No 1 Yes 2 No	
\equiv		00	25. Was case referred to medical examiner? 1 Yes 2 Xe Yes	
o	Phys r this ral di	5	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
n	ding Ph h. After thi funeral	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	
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⋛	or A after Dire	ertif	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the council.	
	Hos 24 h	edicai	29a. Certifier (Check only one) (Check one) (Che	
	o the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	F 3 F 8		1 10 6 A (alber MD) 07/126 (1111 (MA), 1841)	
7	1/		17/4/210100000	
	14.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUX A. GOLDSTEIN MD 7585 OSE DIN H 103 TOWN MD 21204	
89 251 273	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 0 2005	

			For State Registrar	State	of Marylar		artment rtificate				lental Hy	/gien	-000	15715
			1. Decedent's Name (First, Middle,	Last)							2. Date of D Month			3. Time of Death
	Physici /Medic		Michael	Joseph	Roth							D:	ay Year 2005	5:00 A M
	Examin		4a. Facility Name (If not institution,	give street and n	um <i>ber)</i>		4b. City, T	Town, or	Location	of Death			c. County of Dea	
			Montgomery Ge	neral Ho	spital		01ne	≥y				N	lontgome	ry
	Funeral		4	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth	9. Bir	thplace (State or Foreign ountry)
	Director		216-60-3782	1LAM 2LIF	53	Yrs.	Williams	54,5	110010		May 21		51 Sou	th Dakota
	and W		Usual Residence of Decedent 10a. State 10b. County	_	10c C	ity, Town or Lo	cation							10d Incide City Limite
	sho	5	Tob. State											10d. Inside City Limits 1 ☐ Yes 2X No
	the N	ect	Maryland Montgo	mery	D	amascu								
	with	Funeral Directo		a 1 1	n 1		10f. Zip					10g. C	itizen of What Co	ountry?
	s 23	erai	11010 Bethesda			10 10			872				U.S.A.	
	iten d	Ë	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	Armed F		J.S. 13.	was Decede If Yes, speci	ify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	filed within 72 hours after death with the Maryland Hygiene that than "natural", or Items 23a or 28a-f show that the Medical Examinat must be inclifted at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 ∑X No aive Dates:		1 ☐ Yes 2	No	Specify:				Specify:	
Ş	tura	ed	15. Decedent			16a Decer	dent's Usual	l Occupa	ation			16b l	WIN Kind of Business	ite
<u> </u>	n "ne	Completed	(Specify only highesi	grade completed		(Give	kind of work	k done d	furing mos	t of worki	ng		tgomery	
7	with	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Area	Mainte	nan	ce Fs	cili	ties M		_	Schools
9	Hyg otha	Be C	17. Father's Name (First, Middle, L	ast)		, III GG	ila I i i c	Jiidii			(First, Middle	_		
<u>m</u>	id be lentai ked o	ToB	Victor Joseph	Roth						Joyc	e Bro	wn		
Maryland 21215-0036	should ind Men marke umatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numi	ber, City	or Town, State, 2	Zip Code) 20872
	alth a		Shirley M. Roth	- Wife										Maryland
e,	of Hei	1 3	20a. Method of Disposition			Place of Dispo	sition (Nam	e of			ate		ocation - City or	
Ē	Pages nent of I int: If its iry or o		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp							dens	5/12/	05 E	1dersbu	rg, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If itam 27 is marked othar than "naturat, or items 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinat must be inclined at once.		21. Signature of Fun ral Service I	2-2-2-								_	ral Home	
m	De la la la la la la la la la la la la la		Horest L	Nil	liam								Marylan	
			23a. Part1. Enter the disease, or	complications that	caused the dea	th. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory	arrest,	Mar yraiic	Approximate
Е	Physician		shock, or heart failure. List of Immediate Cause (Final			_								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		Hodgki o (or as a consec		ohoma							
Н	Examiner													
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	cuted	mi	cause, Enter Underlying Cause (Disease or injury that initiated events c. Level Lovel T Accident											
0 वर्ष प्रमाण (or as a consequence of):														
8760,	cate be ohysici the bu	dicai	d											
9	ng ph	Med	IF FEMALE:											-
Вох	eath certific attending p	an/h	23b. Was decedent pregnant	. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d. Date of dea	ivery	
	s dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (spe						Month	Day Year
0	that the de led by the a detached f	Physician/Me	9 Unknown											
	S	by	at the Dates argument conditions contributing to death but not resulting in the underlying cause given in Part 1.							23e. Did	d tobacco use contribute to the cause of death?			
ord	w require been sig should t	Completed									1 🗆	Yes 2	X No 3□Pr	obably 4 Unknown
Division of Vital Records,	e law has b	pie									24a. Was		24b. Were au	itopsy findings available completion of cause of
<u>د</u>		Con									perf	ormed?	death?	**
ita	stan: ertific ctor,	Be (25. Was case referred to medical examiner?	T.					26. Place	of Death	Check onl			
7	hysik his ca il dire	ဥ	1 ☐ Yes 2 X No	Hospital: 1 🔀	Inpatient 2	ER/Outpatier	nt 3□ DO/	Othe	r: 4□ Nu	rsing Hor	ne 5 ☐ Res	idence	6 Other (Spe	cify)
U	Attending Physiclan: r death. actor: After this certifica by the funeral director, I	on:	27. Manner of Death 1 XNatural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time of Injury	f 28	c. Injury Work	at ?	2	28d. Describe	how inju	iry occurred	
Sio	eath.	cati	2 Accident investig	ation			М	1 🗆 Y	/es 2□	No				
2	l or At after d Diract I in by	Certification;	3 Suicide 6 Could n 4 Homicide determin	1ed 200. Flat	ce of Injury - At h ding, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory,	office		2	28f. Location City or To	(Street a. wn, Stat	nd Number or Ru e)	ıral Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral		V -											
	Hosp 24 ho Funa tely fi	edical	Conock only Z mieuicai c	Physician: To the xaminer: On the	basis of examin	owledge, death ation and/or in	n occurred a vestigation,	t the tim in my op	e, date an inion, dea	d place, a	and due to the	cause(s , date an	s) and manner as of place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Med	one) 29b. Signature and title of centifier	and ma	nner stated.				number					
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	P		30. Name and address of person		use of death (Ite 18111 Pr			Dri	170 C	1122	Marri	land	20832	
	C.		Joseph Kaplan,		Registrar's Sign		иттъ	DLT	ve, (THEY	, rial y	rand	20032	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg.No.U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY 7, **Physician** 2005 Donald Earle Randle 6:35p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6424 Lochridge Road Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 16, 1930 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F 212-28-8497 74 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Columbia Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6424 Lochridge Road 21044 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 (SYes 2 I No 1953 If Yes, Give
Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married ō 1 ☐ Yes 2 → No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If tiem 27 is marked oth any july or other treumatic event 2008: Be William Byron Randle Cleora Fern Redding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet E. Randle/wife 6424 Lochridge Road Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/10/05 Baltimore, MD Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licenses Cremation Society of Marylan

Dawn F. McDonald

23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final ardiovusevlar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician ar s the burial-tr Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe med? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After DONAld death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

negistiai

Michael E. Silverman, MD

82. Registrar's Signature

11085 Little Patuxent Parkway Suite 101 Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dora Rainier 2005 075 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7 Patapsco Road Linthicum Anne Arundel 8. Date of Birth (Month, Day, Year)
Jan. 28, 1919 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 ☐ KF Maryland 212 09 7668 Yrs 86 **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other then "naturel", or items 23a or 28a-f shov treumatic event, the Medical Examinat must be invitibled at 1 Yes 2 No Director Maryland Linthicum Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Patapsco Road 21090 U.S. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "naturel", or items 23a any injury or other treumatic event, the Medical Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify: White 3 Tx Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Accountant Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Donoho Elma Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Ennis / cousin 909 Hillswood Court Bel Air, Marvland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ⁴ □ Donation 5 □ Other (Specify) Druid Ridge Cemetery 5/9/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Longela 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician terioschero /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atter be detached for a in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 Ninknown 1 ☐ Yes 2 ☐ No Atter this certificate has been situneral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2000 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deout D0006050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONES mo 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ROSENBERGIER

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Month Day Z TH Year KOSEN DUBL **Physician** 2005 12:45 AM MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 10 F 219189205 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show other treumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 2109 U.S. or items 23a 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 New Married 2 Married 1 Yes 2 No Specify: Be Completed by WhI 3 Widowed 4 □ Divorced naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked ott Lanklay Frederick tar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health 2926 Christopher Ave Dalhmore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If eny injury or ŏ 10 105 4 Donation 5 Other (Specify) VIEW rematore 22. Name and Addr. s of Facility 21. Signature of Funeral Service Lice Bradley - Ashby Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner C. DIFF COL Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PSEUDO OBSTRUC 1 Yes 2 No 3 Probably 4 Unknown HEAR 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? GURIA 1 🗆 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident after death Director: 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 7th, 2005 RES 000

State Registrar PRIYANKA

31. Date filed (Month, Day, Year)

9

DHMH 17 Rev 1/2001

LOCH RAVEN BLVD, BALTIMORE, MD-2/239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

SOIN

5604

32. Regarat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item#23a, 27, perME, 6843, 15 Plack Indelible Ink. State of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Health and Mental Hygiene in the state of Maryland / Department of Hygiene in the state of Maryland / Department of Hygiene in the state of Maryland / Department / Thomas M. Raspa unpend 05-3053 1 - For State Registra ΚG Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Thomas Michael Raspa 2005 May 5:20 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7813 Leymar Road Slip #9 Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, May 18, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Min Months Days Hours 1⊠M 2□F 51 219-54-2640 Yrs. Director Mary1and Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location wode 10d. Inside City Limits 7] s marked other than "natural; or items 23a or 28a-f e hor traumatic event, the Medical Evantiner must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7813 Leymar Drive 21060 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Marine Carpenter Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I 1 and 2 should be Michael Paul Raspa ဥ Gertrude Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel J. Raspa / Brother Health Item 27 137 Cardamon Dr., Edgewater, Maryland 21037 other t Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₽= 1 Durial 2 Cremation 3 Removal from State Mav ö permit. Page Department Important: If any Injury or Metro Crematory, Inc. ' 4 □ Onation 5 □ Other (Specify) 2005 Catonsville, Maryland re of Fune al Service Licens Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arteriosclerotic cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate dauge. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 5 Other (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: : After this certification of the thick the th Be 25. Was case referred to medical 26. Place of Death Check on one examiner' 3 DOA Cther: 4 Nursing Home 5 Residence October (Specifyat Scene Hospital: Certification: To 1 XYes 2 □ No 1 🔲 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending death. investigation 1 Yes 2 No 2 Accident 4 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide determined filled in 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) within 24 29b. Signa and title of certifier 29d. Date signed (Month, Day, Year)
May 3, 2005 29c. License number OCME 4 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2005 32. Registrar's Signature

111 Penn Street

Baltimore, Maryland 21201

		•	1 = State Amend Item 20	State of Maryland / b per fh G'43 5-	Departme - Certifica	nt of Health and <i>Te^sof Death</i>	Mental Hy	giene Reg. No. 2005	15720
	*		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic		Virginia			Smith	M44	8 2005	9:51 PM
ja .	Examin		4a. Fecility Name (If not institution, give s		1 _ 1	, Town, or Location of De	ath	4c. County of Dea	
	-		JOHN HOPKINS 5. Social Security Number 6. Sex	7. Age (In yrs. last b.		TMORE of 1 Year If Under 24 F	Irs. 8. Date of Bir	N JA	thplace (State or Foreign
	Funeral Director			M 25 F 69	Yrs. Months		in. (Month, Da	y, Year) C	ountry) MD
			Usuel Residence of Decedent				103.13	1956	
	urylan show		10a. State 10b. County		wn or Location				10d. Inside City Limits
	8a-f	Director	MD HOWARD	ЕЩCO	-				1 ☐ Yes 2 🖪 No
	with the		10e. Street and Number	LANE	10f. Z	ip Code 21042	·	10g. Citizen of What C	ountry?
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.0	or Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 K No		edent of Hispanic Origin? ecify Cuban, Mexican, Pu	erto Rican, etc.)	1	
5-0036	72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show dical Exactinat must be notified at	d by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specity:		Specify: B)	ACK
۲ ک	72 hours "natural", diest Exe	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Us (Give kind of w	ork done during most of	working	16b. Kind of Business	s/Industry
2	filed within Hygiene. Ither than "	mp	Elementery/Secondary (0-12)	College (1-4or 5+)	IITO. DO NOT	BPECIALIST		SOCIAL SE	CHRITY
7		a	17. Father's Name (First, Middle, Last)	N N	.р.о ч		iame (First, Middle	, Maiden Sumame)	CORCITY
Maryland		To B	MONROE SIMMS			VIRGIN	JIA TAY	-OR	
ary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty			ss (Street and Number or		- Contract	
	and and and mark					The state of the s		ICOTI CITY	mo 21042
000	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemete	of Disposition (N	other place)	13-05	20c. Location - City o	
Baltimore,	it. Pa intmer intent: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer (1) Service License	GARR					VILLZ WID
Ba	permit. Page Department Important: Il sny injury o		2) ans		VAUGHN	ALTO NATE P	FUNERAL S	ERVICE 3. MD 2122	79
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	diabetic ket	togcide	2515			Onset and Death
3	/Medical		resulting in death)	Due to (or as a consequence					~ - 13
	Examiner		Sequentially list conditions, if any leading to immediate						
	bed isit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	9 of):				
•	xecut and al-trar	xan	that initiated events resulting in death) Last	. Due to (or as a consequence	e of):				-
58760,	icate be executed physician and s the burial-transit	edicai E							
_			IS SCHOOL S						
P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending piral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3∐Ectopic	pregnancy		23d. Date of de Month	elivery Day Year
	to the dea by the at tached for	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Wildian	Day
	that the ed by detac	Ph.	Part II. Other significant conditions cor	tributing to death but not resulting	in the underlying	cause given in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
g,	w requires that been signed b should be deta		aspiration pre	amonia	, ,	-	1 🗆	Yes 2 € No 3 ☐ F	robably 4 Unknown
S	s beer	olete					24a. Was		utopsy findings available
Re	The lav te has	Completed					uto perfe 1 Yes	ormed? death?	completion of cause of s 251No
g	ilan: srtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of	Death (Check only		
<u>></u>	hysic this ce al dire	၉	1 ☐ Yes 2 ■ No	ospital: 1 Inpatient 2 ER/C				dence 6 Other (Sp	ecify)
n C	ling P	ion:	27. Manner of Death 1 ■ Naturat 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b.	. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Division of Vital Records,	Attending or death. ector: Atler by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,			28f. Location (Street and Number or F	Rural Route Number,
<u>S</u>	al or / after I Dire d in b	Certification:	4 Homicide determined	building, etc. (Specify)		,,	City or To	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his peripherely filled in by the funeral director, page		29a. Certifier 1 ✓ Certifying Phys (Check only 2 ☐ Medical Exami	sician: To the best of my knowledger: On the basis of examination a	ge, death occurre	d at the time, date and pl	ace, and due to the	cause(s) and manner a	is stated.
	the H in 24 the Fi nplete	edical	one)	and manner stated.			ccorrect at the time,		``
		2	29b. Signature and title of certifier	+0	2	9c. License number	00	29d. Date signed (Mor	· · · · · · · · · · · · · · · · · · ·
	0.0		30. Name and address of person who co	metho Mo	A (Type Brief)	~ C 3 - O		riay o.	2005
•	10		Nisa Marutha	r 600 North	Wolfe	Street !	Baltimor	e, Maryla.	nd 21287
	Sta	ite	31. Date filed (Month, Day, Year)		Costs				-
	Registi		MAY 1 () 211(15	Filmer Jos Pa	-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend item #7,8,10c&f per fh @ #20709 earth dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical (If r t institution, give street and number) 4b. City Town, or Location of Death Examiner Hi ora 8. Date of Birth 1946 If Under 24 Hrs. If Under 1 Year T Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Hours 219-44-600 59 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Completed by Funeral Director Harton 1 Yes 2 No **JARRETTSVILLE** Street and Number 10g. Citizen of What Country? 21084 Was Decedent E Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. er in U.S. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tomotive nanaa 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S) eet and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 7ay 10,2005 3 ☐Removal from State Evans Funeral Chapel ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVQNS Forest Hill annel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lung disease or condition resulting in death) cancer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ^oL 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) osal ungens mo D60203 2005 30. Name a addres of perso o completed cause of death (Item 23a) (Type, Print) 21231 Rosalyn Juerye.
31. Date fied (Month, Day, Jear)
MAY 1 0 2005 1650 Orleans Street Johns Hopkins Juergensus Baltimore

State Registrar

DHMH 17 Rev 1/200

🚅. Registrar's Signature

	-	State of Maryland / Department State of Maryland / Department Certification	nt of Health and M te of Death		ene	5 15722
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Raymond J. STROBEL		2. Date of Death Month		Year 2005 3. Time of Death
Examina Funeral Director		NORTH ARUNDEL HOSPITAL GI	Town, or Location of Death FN DURNE or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	4c. County ANNE	of Death
r 28a-f show	for	10a. State 10b. County 10c. City, Town or Location	nton			10d. Inside City Limits 1 ☐ Yes 2 📈
th with the 23a or 28a ust be notil	I Director	10e. Street and Number 1212 Odenton Road Apt. 420	Code 21113	10	g. Citizen of V	Vhat Country? USA
urs after dea II', or Items Xdminer m	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e · Ame <i>ri</i> can Indian, k, White, etc.
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s should be fitled within and Mental Hygiene. Is marked other than aumatic avent, the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Men	To Be	17. Father's Name (First, Middle, Last) Raymond Benjamin Strobel	Ros	e (First, Middle, M se Ewerth		
Health tam 27 othar tr		· · · · · · · · · · · · · · · · · · ·	other place)	San Ang	elo, T	
permit. Pages Department of Important: If i any injury or once.		21. Signature of Fin. al Service Licensee Dawn F. McDonald 299 F	rions Society rederick Road	of Maryl	and, I	nc.
Physician /Medical Examiner the pnial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Chronic necessary Chronic necessary Due to (or as a consequence of): Chronic necessary Due to (or as a consequence of): Due to (or as a consequence of):	0 .			I mmh
death certification at the difference as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p			23d. Dat Mor	e of delivery nth Day Year
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ate has b	Completed			24a. Was an autopsy perform	24b. V ed? c	Were autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☐ No
his II dii	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Do	OA Other: 4 Nursing Ho	h <i>(Check only one</i> ome 5□ Resider	nce 6 Othe	
or Attanding ifter death. Director: After in by the funer	Certification:	27. Manner of Death 1	Work? 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	eet and Numbe	ed er or Rural Route Number,
the Hospital in 24 hours a the Funeral I mpletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred control of the basis of examination and/or investigation and manner stated.	f at the time, date and place, n, in my opinion, death occur	and due to the cau	use(s) and ma te and place, a	nner as stated. and due to the cause(s)
with:	1	* Street Laws ms	c. License number OC22463		A .	(Month, Day, Year)
0"	te	30. Name and address of person impleted cause of death (Item 23a) (Type, Print) TUNET INCOS MD 30S IJOS AT 31. Date filed (Month, Day, Year) 32. Registrar's Signature	IB. GL	un Burni	ie mi	0 2106

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 90051 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year SMITH WARREN MAY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Pavs Hours Min. (Month, Day, Year) 1301 SECOURS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F 19-72-696 416 Yrs. MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant; if item 27 is marked other than "natural; or items 23e or 28e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examinativist be notified at Baltimore Director 1 Xes 2 No mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2324 ZIZZ Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 | No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) onstruction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Witherspoor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tayette itam 27 BILLOMO SISS3 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 5-13-05 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 119-121 S. Strickerst 22. Name and Address of Fability Balto. Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Wonge 4 Due to (or as a consequence of): Box 68760 Physician/Medicai as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Year Month 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 X No 1 🗌 Yes 2 **X**No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DOA 3 DOA P 1 ☐ Yes 2 No 1 Inpatient this 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2.
To tha I complete 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7543 PHYSILIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940, W. BALTIMURE ST, BALTIMORE, MO21283 SANDHU MD INDER State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SUBERO Day Physician IND 1350 2001 MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLS. SALTIMORE HOSPITAL TOWN NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF 114-42-0513 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 28a-f ahow ir than "natural", or itema 23a or 28a-f ahov the Medical Examinar must be notified at es 2 No Completed by Funeral Director Himore 10g. Citizen of What Country? 10f. Zip Code 211 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. De NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) ollege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Pages 1 and 2 should be 19a Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, Cit 1029 vieco. OL 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Department of H Importent: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State 10/05 Conation 5 ☐ Other (Specify) Signature of Auneral C. Greene Funeral The state of the s 23a. Part1 En er the disease, or um show heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMORPHAGE Physician NTRA CRANIAL Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 (10 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MO 21133 AVI . Registrar's Signature State

Registrar

			State of Manuard / Department of Health and M	•	_
			State of Maryland / Department of Health and N 1- State Registrar State Of Maryland / Department of Health and N Certificate of Death		7005 15775
		-	1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death	3. Time of Death
	Physicia /Medic		Naomi M. Stadler	Month 5	2005 /2:17PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	0	4c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Bo-/+ MOPE 9. Birthplace (State or Foreign
	Funeral Director		216 18 9970 1 Months Days Hours Min.	Aug. 27,	1921 Maryland
	dand ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	death with the Maryland rns 23s or 28s-f show r must be notified at	Director	Maryland Baltimore Dundalk	100	1 ☐ Yes 2X No
	with t		10e. Street and Number 1909 Kelmore Road 21222	Tog	p. Citizen of What Country?
	death ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - American Indian,
س ا س ا س ا	be filed within 72 hours after death with the Marylar ital Hygiene. So of other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 3 No Specify:	Hican, etc.)	Specify: White
E 9	2 hou	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	16	8b. Kind of Business/Industry
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fand	2 should be filed within and Mental Hyglene. Is marked other than aumatic event, the Mental Manage.	To Be	17. Father's Name (First, Middle, Last) unknown 18. Mother's Name unkn	e (First, Middle, Ma OWN	iden Sumame)
Mary	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Mabel Pindell / Daughter 19b. Mailing Address (Street and Number or Rural 1909 Kelmore Road D		City or Town, State, Zip Code) laryland 21222
re,	es 1 and 2 of Health I item 27 I		and the state of t	Date 20	c. Location - City or Town, State
S+&	permit. Pages Department of I Important: If it any injury or o		'4 Donation 5 Other (Specify) Holy Cross Cemetery 5/4/2		Baltimore, Maryland
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
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orc	w requires been sign should be	eted		1 🗆 Yes	/
(2) Division of Vital Records,	The law sete has b page 2 s	ompi		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
ital	ician: Th certificete rector, pag	Be C	25. Was case referred to medical 26. Place of Death	1 Ves 2 h (Check only one)	10 10 2010
>	Physician: this certific al director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient YER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residenc	ce 6 Other (Specify)
0	ng Pt fter th	no:	27. Mannagof Death 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work?	28d. Describe how	injury occurred
Sio	ttending Ph death. ctor: After th y the funeral	catio	2 Accident investigation M 1 Yes 2 No		
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cau red at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the Mithin To the Comple	Me	29b. Signature and title of certifier 29c. License number	290	. Date signed (Month, Day, Year)
	- 2- 0		I Stone Glencin) 053345		5/1/05
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	^	
_			Pr. Thomas Krisanda 9000 Franklin source Dri	ve Bo	1+1more, m) 2/237
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pr. Thomas Krisanda 9000 Franklin 50, uare Dri 31. Date filed (Month, Day, Year) 32. Registra Signature MAY 1 0 2005		

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	•	1 - State Amend Item 5	per ff 6843 5-1	3-05 tas Certifica	te of Death		Reg. No	.003	13/26
DI		1. Decedent's Name (First, Middle, Last)				2. Date of D			3. Time of Death
Physicia /Medic		anneliese S.	SABO			MA		3 2005	6:00 A
Examin		4a. Facility Name (If not institution, give s NORTH ARUNDEL	treet and number)		GLEN 1	BURNIE	l ³	ANNE	PRUNDEL
Funeral		5. Social Security Number 6. Sex 1610	7. Age (In yrs. last	birthday) If Und Months	er 1 Year If Under: Days Hours	Min. (Month, L		9. Birth	nplace (State or Forei untry)
Director		536-38-1-61-6 Usual Residence of Decedent	76	TIS.		9/30/1	928	Gern	nany
ow a		10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limi
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h the	lrec	10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,		ip Code		10g. Cit	izen of What Co	untry?
15 will	a	1823 Cedar Dr.		21	144		USA		
be lited within 72 hours after death with the Marylan Hyglene. Hyglene, the Hyglene do other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Dec If Yes, sp	edent of Hispanic Origecify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	lo-	14. Race - Ame Black, White	
within 72 hours after death with the Maryland ene. Han "natural", or items 23a or 28a-f show the Meulcal Examiner must be notified at	þ	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:			Specify:Whi	te
"natu	Completed	15. Decedent's Educ (Specify only highest grade		6a. Decedent's Us (Give kind of v	rork done during most	of working	16b. K	ind of Business/l	ndustry
withir	E P	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retirea)		177	1	
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and 2 salth a n 27 is		Renate Bass (sister	r) 1	02 Crain	Hwy, N. A	pt 931 Gle	n Bu	rnie. MI	21061
ss 1 and 2 of Health Item 27 i		20a. Method of Disposition	20b. Place	e of Disposition (Netery, crematory or	ame of	Date		ocation · City or	
Pages nent of P ant: If Ite ary or of		1 Burial 2 Cremation 3 R 4 Quonation 5 Other (Specify)	emoval from State		' '	ay 7, 2005	Renol	klam Mo	
permit. Pages Department of Important: If I any injury or once.		21. Sign ture of Fune al Servi > License	96	22. Name Kirk	and Address of Facility Ley-Ruddic	k Funeral	Home	,P.A.	
		23a. Part1. Enter the disease, or compli	cations that caused the death. D			S.E. Gler		nie, MD	21061 Approximate
nysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		rcephalo	athy				Interval Between Onset and Death 3 days
Examiner	_		Due to (or as a consequent	a Intar	ction		AIC .		3 days
Pa ist	Examiner	Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury	Other or as a consequent	YUS15					11
cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a consequent						Trans
cate be executed physician and the burial-transit	dicalE								
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death certifica attending phater use as to	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea					23d. Date of deli	very
The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 MrNo 9 □ Unknown	4☐Pregnant at time of death					Month	Day Year
that ti ed by detac		Part II. Other significant conditions con	stributing to death but not resulting	ng in the underlying	cause given in Part I.	23e, Dio	tobacco	use contribute to	the cause of death?
urres tha signed I Id be det	d by	SICK SINUS Jynd			3		Yes 2		
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the fire	\vdash	27. Manner of Death 1 ☑Natural 5 ☐ Pending		b. Time of Injury	28c. Injury at Work?	28d. Describe			ary)
or Attending after death, Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	M farm street facts	1 Yes 2 i		/Stroot = -	nd Number == F	ral Route Number.
i te	Certification;	4 Homicide determined	building, etc. (Specify)	s, rann, street, racti	ry, othoe		own, State		rai noute Number,
To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier (Chack only one)	sician: To the best of my knowled ler. On the basis of examination and manner stated.	dge, death occurre	d at the time, date and	d place, and due to the	e cause(s) i, date and) and manner as a place, and due	stated. to the cause(s)
omple	Me	29b. Signature and title of certifier	1	2	9c. License number	_	29d. Da	te signed (Month	, Day, Year)
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1		30. Name and address of person to co	mpleted cause of death (Item 23			. Glen B		•	
			OBS MD 3	US Nos	x.0 0.	Calan B	DVN	o mn	2100
		31. Date filed (Month, Day, Year)	د حداد دواد	OZ Hos	piles ur	. O-WA IJ	· / //	ر ما الريا	YINA

amend item#12, perFH G843, 5/10/05 The State of Maryland / Department of Health and Mental Hygiene 0 55 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MA Y **Physician** 2005 MERVIN SHPRITZ 6:45 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/21/1918 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 86 214-18-2659 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho Director 1 ☐ Yes 2 ☑ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 OLD POST DRIVE #6 21208 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 227 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No WHITE Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 Is marked other II any injury or other traumatic event, III once. FURNITURE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) SHPRITZ BARNETT MARY 2 **EDELSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEE SHPRITZ / SON 2 HOUNDS HOLLOW COURT OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 05/09/2005 WOODLAWN, MD 21. Signature of Fuperal Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or com-shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 🗆 Yes 3 Probably 4 Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed Division of Vital 1 ☐ Yes 2 No 1 Tes 2 🗆 No funeral director. 25. Was case referred to medical 26. Place Death (Check only one) examiner' Other: P 1 Yes 2 No 4 Unursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 1 - atural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) 210 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 2005

			partment of Health and Mertificate of Death		energe 05 15728
Physic /Med		1. Decedent's Name (First, Middle, Last) Robert S	Sweeney Sr	2. Date of Death Month MGY	Day ZV Year 3. Time of Death 7, VDH M
Exami		4a. Fagility Name (If not institution, give street and number)	4b. City, Town, or Location of Beath	からん	4c. County of Death Annal 2
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 12 − 28 − 9632 12 − 12 F 73 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day,) May 22 1	9. Birthplace (State or Foreign 931 Mary land
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel Glen Bu			10d. Inside City Limits 1 □ Yes 2 1 No
with the sa or 28a-	Director	10e. Street and Number 1022 Rose Anne Dr.	10f. Zip Code 21061	100	g. Citizen of What Country?
be filed within 72 hours after death with the Maryland tall Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Modical Evarriner must be notified at	by Funeral		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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should be filed and Mental Hygies marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Joseph V Sweeney		e (First, Middle, Ma	aiden Surname)
nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Joseph S. Sweeney son 92	ling Address <i>(Street and Number or Rur.</i> 0 E .Sv. 46 Geneva	Fla 3273	City or Town, State, Zip Code) 2
m 0 .			position (Name of the place) aven Cemetery 5/9/(oc. Location - City or Town, State
parmit. Page Department of Important: If any injury or once.		21. Signature of Fyneral Service Licentee			Funeral Home P.A. ena Md 21122
/Medical Examiner buysician and physician and sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that cause the death. Do not e shock, or heart failura. List only one cause on etc. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Lympho (The spiratory areas	Approximate Interval Between Onset and Death Onset and Death
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	O	building, etc. (Specify) 29a. Certifier Certifying Physicien: To the best of my knowledge, dea	ith occurred at the time, date and place.	City or Town,	State)
To the Hospitel or within 24 hours after To the Funeral Dir.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	ed at the time, date	e and place, and due to the cause(s) I. Dale signed (Month, Day, Year)
le		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Harrital	Av	Glam Burnit
St	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature			(h

Robert Swaring

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	Physici		1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	3. Time of Death		
	/Medic	_	Howard David Taylor		may	08 2005 8:10 AM		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Caton Manor Genesis Eldercare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	N/A		
	Funeral Director		217-26-1907 To M 2 F To Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Ye.	ar) 9. Birthplace (State or Foreign Country) Maryland		
	yland yland		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits		
	B-fel	ctor	Maryland Baltimore	Catonsville		1 ☐ Yes 2 ☐XNo		
	ith the	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	ath w	rai	519 Ingleside Avenue	21228		USA		
	er de Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.		
326	irs aft		1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 3 ሺ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White		
ğ	2 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Industry		
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Items 23a or 28a-f show aumatic event, the Marical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (•		
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Z Z	~ ~ ~ ~			Clammona Arranga C				
	1 and 1 Health tem 27 other tr		20a. Method of Disposition 20b. Place of Disp	position (Name of Da		Le, MD 21228 Location - City or Town, State		
Baltimore,	permit. Pages Department of I Important: If it any injury or o		Meadowr1	ematory or other place) .dge 5/11/6		lkridge, MD		
	nit. Fi		MEHIOLIAI	Park		ikridge, rib		
ñ	Per Per Per Per Per Per Per Per Per Per		Edward A. Gregorchik	22. Name and Address of Facility TacNabb Funeral Home BOI Frederick Road O	e, P.A. Latonsvil	le. MD 21228		
	200		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between		
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	/Medical		resulting in death) Due to (or as a consequence of):	Denie Williams		7 - 9035		
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	and and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
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ō	Phys r this ral di	. To	1 Inpatient 2 ER/Outpatie	ant 3 DOA 4 A ursing Home	 5 ☐ Residence d. Describe how in 	6 □Other (Specify)		
o	nding f th. : After s funers	ition	27. Manner of Death 1	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,		
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1	0			.Print) ens Avenue Baltimon	re, MD 21	229		
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 0 2005 32. Rejistrar's Signature	porter				

		_	- For amend ite Registr amend ite	State of M m #19a PE #5#19a pe	Maryland / Do R INF C843 r fh g843	partment of 5/17/05	Health ar)5 15730
	Physicia	an	Decedent's Name (First, Middle, William Charles		Jr.			2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number	ar)	4b. City, Town,		Death	4c. County	of Death
			Saint Joseph		l Center Age (In yrs. last birth	day) If Under 1 Year		₩50Tl 4 Hrs. 8. Date of Birt	•	Baltimore
Ľ	Funeral Director		5. Social Security Number 2927 216-16-2929	1 X M 2□F	81 Yr	Months Days		Min. (Month, Day	y, _{Year)} 1924	9. Birthplace (State or Foreign Country) DE
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl a-f sho	tor	MD Baltimo	re	Time	onium				1 □Yes 🛣 No
	or 284	Director	10e. Street and Number	· ·		10f. Zip Code			10g. Citizen of	What Country?
	eath v	ra	12 E. Aylesbury	Rd.	nt Ever in U.S.		1093	n? (Specify Yes or No	USA 14 Bac	A ce - American Indian,
9	after d or itam		1 Never Married 2 Married	Armed Force	s?			n? (Specify Yes or No- Puerto Rican, etc.)		ck, White, etc.
5-0036	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show official Extratoric ust by molified at	d by	3 Widowed 4 Divorced	Year or Date	s:	1 □ Yes 2 □ No			Specif	wille
215		Completed	15. Decedent's (Specify only highest	grade completed)	(lecedent's Usual Occu Give kind of work done ife. DO NOT use retir	e durina most d	of working	16b. Kind of B	usiness/Industry
2121	filed within Hygiene. other than " ant, I're Man	Com	Elementary/Secondary (0-12)	College (1-40 n/a	El	ectronics	Technie	cian	Manufa	acturing
Maryland		Be	17. Father's Name (First, Middle, La William Toffry	st)			18. Mother's	s Name (First, Middle, Vasev	Maiden Sumar	ne)
aryl	S E E	C	19a Informant's Name/Relationship	(Type, Print)	19b. l	Mailing Address (Stree		or Rural Route Numbe	er, City or Town	State, Zip Code)
	C - N -		June Toffry, Jr				ury Ro	J., Timonii		
Baltimore,	ita off		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	☐Removal from Sta	te cemetery,	Disposition (Name of crematory or other pl	· 1	Date		- City or Town, State
altin	- t t t t	1	4 Donation 5 Other (Spe 21. Stroature of Euneral Service Lin		Cedar	Hill Ceme	ress of Facility	18 0100 010		urnie, MD
ä	Depar Depar Impo any ir			mmyri ka	on	Lemmon F 10 W. Pa	iuneral donia F	Home of D Rd., Timor	Dulaney Dium, M	Valley, Inc. D 21093
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that causely one cause on each	sed the death. Do no n line.	t enter the mode of dy	ving, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		STATIC C		OMA TO	THE LUN	IGS	MONTHS
	Examiner		Sequentially list conditions	b	as a consequence of					
,	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of):				
· .	be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):				
8760,	ate be executed hysician and the burial-transit	dicai	104	d						
9	leath certific attending pl	/Mec	IF FEMALE:	23c. If yes, outcor	ne of pregnancy	·			004 D-	A - 4 4 1 1 1
. Box	death certific e attending p od for use as	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnani	2 Fetal death at time of death	3 Ectopic pregnant 5 Other (specify)	cy			ite of delivery onth Day Year
P.0	at the de d by the etached	Physician/Me	9 ☐ Unknown	9□ Unknowr						
Ś	requires that the reen signed by th hould be detache	by	Part II. Other significant condition END- STAGE R			he underlying cause g	pven in Part I.	23e. Did to	V	tribute to the cause of death? 3 Probably 4 Unknown
COL	w requ	iete	CORONARY ARTER	Y DISEASE	_			24a. Was	12	Were autopsy findings available
ital Record	The law ate has b page 2 s	Completed						autop perfor	rmad/?	prior to completion of cause of death? 1 ☐ Yes 2 XNo
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only o		
o	Phys rthis ral dii	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. D te of l	njury 28b. Tir	ationt 3 DOA		sing Home 5 Resid		
ion	Attending I ir death. actor: After by the funer	atio	1 Natural 5 Pending investiga	tion	<i>Day Year)</i> Inj		ork? □Yes 2□No	0		
Division	F 하 F C	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of	Injury - At home, fam etc. (Specify)	n, street, factory, office	÷	28f. Location (S City or Tow		per or Rural Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge,	death occurred at the	time, date and	place, and due to the	cause(s) and ma	anner as stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner	s of examination and/	or investigation, in my	opinion, death	occurred at the time,	date and place,	and due to the cause(s)
	To To	2	29b. Signature and title of centifier	Ho Pari	M.D		nse number		29d. Date signe	d (Month, Day, Year)
	0		30. Name and address of person w				17695	/		, , 2003
						A AND AND I DOWN THE	DRIVE	TOWSON,	MARYLA	ND 21204
	Sta Registr	100	31. Date The Month, Day, Year?	2005	strår's Signature			,		
		i i s	MAY 1 0	LUUJ 28	West Str					

DHMH 17 Rev 1/2001

Registrar

			•	State of Maryland		rtment of Heal		ental Hygie	a UUU	15732
		9		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
		Physici		Richard E. Trader, Jr.				Month May 8.	Day Year 2005	1:45PM M
		/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		110.7	4c. County of Deat	
	1	LXaiiiii	-	Gilchrist Center for Hospice Car	re	Towson			Balti	nore
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year If U	Jnder 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
		Director		218-40-0008 ¹ŒM 2□F 64	Yrs.	Months Days Ho	ours Min.	8. Date of Birth (Month, Day, Ye Feb. 9,19	41	MD
		ъ		Usual Residence of Decedent						
		ylan		10a. State 10b. County 10c. City, 7	Town or Loc	cation				10d. Inside City Limits
		Mar Sef 8	to	MD Baltimore	Owin	ngs Mills				1 ☐ Yes 2X No
		r 28	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
		3a o	JE D	6 Gwynnbrook Ave.		2111	7		USA	
		ours after death with the Marylan rei', or items 23a or 28e-f show Exportment be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe	ecify Yes or No-	14. Race - Ame Black, Whit	
	9	atter or Ite	Ē	1 ☐ Never Married 2 【 Married 1 】 Yes 2 ☐ No If Yes, Give			exicall, I dello	ricari, etc.)		9, 610.
0	93	ours a	b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		L 165 28 100 3	ocity.		Specify: Wh	ite
5	21215-0036	tiled within 72 hours atter death with the Maryland Hygiene. uther than "naturel", or tleme 23a or 28e-f show uther than "naturel", or tleme 23a or 28e-f show ant, the Maxical Exterior to the houtfied at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation kind of work done during	a most of work	168	o. Kind of Business	Industry
1	21	thin e.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired)	,			
	2	e tiled within at Hygiene. I other than vent, the Ma	5	12	Commer	cial Kitch			Acme	Paper
art	pu	at Hy at Hy d oth	Be (17. Father's Name (First, Middle, Last)		18.	Mother's Name	(First, Middle, Mai	den Sumame)	
	<u>a</u>	Vid b Vients rked rked	٦ 2	Richard E. Trader, Sr.			Nancy	Mortilla	iro	
Ry 8, 2005	Baltimore, Maryland	d 2 should be tiled within 72 hc th and Mental Hygiene. 7 Is marked other than "natu treumatic event, the Madical		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and I	Vumber or Aura	I Route Number, C	ity or Town, State, 2	Zip Code)
Ŏ	Σ	Health a tem 27 ls		Jain A. Trader Wife	6 Gwy	nnbrook Av	e., Owi	ngs Mills	s, MD 211	17
3	e,	of Healt item 2 other		Zod. Motrica of Disposition	ce of Dispos	sition (Name of natory or other place)		Date 200	c. Location - City or	Town, State
00	E	Page ent c nt: If ry or		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Carr	ro11 (Cremation	5/12	/05	Hampstead	1. MD
_	Ħ	permit. Pages: Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee		Name and Address of		·		stown Road
3	B	Depar Impor eny ir		Item ham M. Hent	E1	line Funera	1 Home		erstown,	
\equiv		_		23a. Part1. Enter the disease, or complications that caused the death.						Approximate Interval Between
		Diam'r.		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	21-	Coteral	Col	212515		Onset and Death
		Physician /Medical		disease or condition resulting in death) Due to (or as a conseque	JUICE Offi	Carred !	201	100313		9243
		Examiner	8	Due to (01 29 2 conseque	irica oi).					
			-G	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	nce of):					
		led nsit	Examiner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause (Disease or injury						
	_	and and II-tra	xar	that initiated events c	nce of):					
2	8760	cate be executed physician and the burial-transit	a E							
Jan.	87	phy:	dical	d						
Z	ox 6	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnance	cv				23d. Date of de	iverv
5	Во	atten atten for us	ian	in the past 12 months?	leath 3 🗌	Ectopic pregnancy Other (specify)			Month	Day Year
)	Ö	the a	ysic	1 Yes 2 No 9 Unknown	iii 3	Other (specify)				
2	σ.	that the de ed by the detached		Part II. Other significant conditions contributing to death but not result	ting in the un	nderlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of death?
-	S,	signed d be det	by	Turkin, Gallot Giganitation and a second a second and cond and cond and cond a second a second a		,		1 ☐ Yes	2. No 3 □ P	robably 4 Unknown
7	ecord	requi	Completed					-		
if	ec	law lasb	pje					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
10	<u>R</u>	The ate h page	Son					performe 1 ☐ Yes 2 V		2 🗆 No
3	Vital	ien: artitic ctor,	Be (25. Was case referred to medical examiner?		26	Place of Deat	n (Check only one)		
1		yslc nis ce dire	2		R/Outpatien	t 3 DOA Other:	1 ☐ Nursing Ho	me 5 Residenc	e 6 Other (Spe	city) hospièp
	J of	ig Pt ter th		27. Manner of Death 1 SNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 2	28b. Time of Injury	28c. Injury at Work?		28d. Describe how	injury occurred	•
1	Division	ath. r: Af	atic	2 Accident investigation	, ,		2 🗆 No			
	Vis	Atte	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		281. Location (Stree City or Town, S		ural Route Number,
	Ö	s afte	Certification:	30.00.00						
		ospit hour unere ly tille		29a. Certifier Certifying Physician: To the best of my know (Check only 2 Medical Examiner: On the basis of examination)						
		To the Hospitel or Attending Physicien: The law requir within 24 hours atter death. To the Funerel Director: After this certilicate has been s' completely tilled in by the funeral director, page 2 should	Medicai	one) and manner stated.	on and or in					
		To To	2	29b. Signature and sale of certifier		29c. License nu	_		Date signed (Moni	n, cay, rear)
		, 1		- Alemans		V > 8	303	V	1. M.	7007
	1	610		30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print) Prazios St	(2-1+	mas M	DEIZOLI	
	1	· '		ABOUT CHARLES OND 6601	1 1 C	V 605107 01	2101	1000	- 7	
		St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 0 2005 32. Figistrar's Signatu	k 1	acti)				

			For	State of Maryland	d / Department of Health	and Mental Hy	gienenns 15723
			1 - For State Registrar		Certificate of Death	h	Reg. No.
	Physici	an	1. Decedent's Name (First, Middle, Las	,		2. Date of De.	ath 3. Time of Death
	/Media	al	SHANKARAMMI		VENKATADASA 4b. City, Town, or Location		4c. County of Death
	Examir	er	4a. Facility Name (If not institution, give	, , , , , , ,	Be DE as well	Cifi	4c. County of Death
	Funeral		5. Social Security Number 6.49	Ocens Son Str 9x 7. Age (In yrs. Ia		er 24 Hrs. B. Date of Birt Min. (Month, Da	9. Birthplace (State or Foreign
L	Director		VI 1-73 1000	□M 20F	13 Yrs. Months Days Hours	Min. (Month, Da	y, Year) Country) 32 T.ND/A
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location		10d. Inside City Limits
	Mary I-f sh	tor	MD House		Columbia		1 □ Yes 2 No
	th the	lrec	10e. Street and Number	14	10f. Zip Code		10g. Citizen of What Country?
	ath wi	rai	6734 Carlina	la Ave.	21040	0	India
	er dez Itams	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	 Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 	origin? (Specify Yes or No an, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 No Specifi	y:	Specify: Tudian
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Itams 23a or 28a-f show the Medical Exercites mast be recitived.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupation	net of working	16b. Kind of Business/Industry
2	within ene. then "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)	ost of Working	A 1 6
	ba filed wital Hygier of other tiles	Co	17. Father's Name (First, Middle, Last)		nomemaker 18 Mari	her's Name (First, Middle,	Mairlen Sumama)
and	Mental Harked of	To Be		AGASAPPA	10. 1400	00 127 0V	made comains
Maryland	2 should I and Men Is marker sumatic	-	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street and Numi	ber or Rural Route Number	er, City or Town, State, Zip Code) 21542
	t and 2 Health a tem 27 Is		SURSIAN MAR	AYAN	6734LABLINDE	4 AVE- ECH	ombia Marsharo
ore	Pagas 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐	Removal from State	ace of Disposition (Name of metery, crematory or other place)	Date	20c. Location - City or Town, State
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. mportant: If item 27 is marked other then "naturel", or Itams 23a or 28a-f show any injury or other traumatic event, it.e. Medical Exercities matched to collised and the recities of the angles.		`4 □ Denation 5 □ Other (Specify	" CUAL	JZ EUNSDAT CHOPINA	5-9-05	rorest Hill MD
Bal	permit. Pagas Department of t Important: If ite any injury or of once.		21. Six ture of Fulleral Service Licen	y I	22. Name and Address of Faci		RE, MD 21234
			23a. Part1. Enter the disease, or comp	plications that caused the death	. Do not enter the mode of dying, such a		RCO HARFORD RD . Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition		YOCARDIAL IN	EARCTIO	Interval Between Onset and Death 6 HOURS
	/Medical Examiner		resulting in death)	Due to (or as a consequ		- ///	.0 110023
	Examine	_	Sequentially list conditions,	b. Due to (or as a consequ	ence of):		
	insit	ine	if any, leading to immediate	Due to (of as a consequ	orioo orj.		
Ć	in or	Ε	Cause (Disease or injury				
	exa an a rial-	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):		
376(ate be exa hysician a he burial	cai	Cause (Disease or injury that initiated events		ence of):		
x 68760,	ertificate be exacuted ling physician and e as the burial-transit	cai	Cause (Disease or injury that initiated events	Due to (or as a consequent of d.	·-		
Box 6	eath certificate be exe attending physician a for use as the burial-	cai	Cause (Disease or injury that initiated svents resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence). d. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal	ncy death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Box 6	ithe death certificate be exe by the attending physician a ached for use as the burial-	cai	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of d. 23c. If yes, outcome of pregnar	ncy death 3 Ectopic pregnancy		
P.O. Box 6	ss that the death certificate be exe gned by the attending physician a be detached for use as the burial-	Physician/Medicai	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequent). d. 23c. If yes, outcome of pregnant 1 Dive birth 2 Fetal 4 Pregnant at time of de 9 Unknown	ncy death 3 Ectopic pregnancy	t I. 23e. Did t	
P.O. Box 6	equires that the death certificate be exe een signed by the attending physician a tould be detached for use as the burial-	by Physician/Medicai	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequent). d. 23c. If yes, outcome of pregnant 1 Dive birth 2 Fetal 4 Pregnant at time of de 9 Unknown	ncy death 3 □ Ectopic pregnancy ath 5 □ Other (specify)	t I. 23e. Did t	Month Day Year obacco use contribute to the cause of death?
P.O. Box 6	e law requires that the death certificate be exe has been signed by the attending physician a e 2 should be detached for use as the burial-	by Physician/Medicai	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequent). d. 23c. If yes, outcome of pregnant 1 Dive birth 2 Fetal 4 Pregnant at time of de 9 Unknown	ncy death 3 □ Ectopic pregnancy ath 5 □ Other (specify)	1 \(\) 24a. Was autop	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 □ Probably 4 □ Unknown an 24b. Were autopsy findings available prior to completion of cause of
Records, P.O. Box 6	n: The law requires that the death certificate be exe licate has been signed by the attending physician a r, page 2 should be detached for use as the burial-	Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent). d. 23c. If yes, outcome of pregnant 1 Dive birth 2 Fetal 4 Pregnant at time of de 9 Unknown	ncy death 3 □Ectopic pregnancy ath 5 □ Other (specify) Iting in the underlying cause given in Pari	1 _\frac{1}{24a. Was autor perto 1 _\frac{1}{2} \text{ Yes}	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No
Records, P.O. Box 6	rsicien: The law requires that the death certificate be exe s certificate has been signed by the attending physician a lirector, page 2 should be detached for use as the burial-	Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions of examiner?	Due to (or as a consequent of the consequent of	ncy death 3 Ectopic pregnancy ath 5 Other (specify) Iting in the underlying cause given in Part	24a. Was autoped to perform the Yes	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Records, P.O. Box 6	Physicien: The law requires that the death certificate the been signed by the attending this certificate has been signed by the attending all director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a consequent of the consequent of	death 3 Ectopic pregnancy ath 5 Other (specify) Iting in the underlying cause given in Parl	24a. Was autor performed to the control of the cont	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No
Records, P.O. Box 6	ling Physicien: The law requires that the death certifi h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	death 3 Ectopic pregnancy ath 5 Other (specify) Iting in the underlying cause given in Parl	24a. Was autor perfo	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an observation of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No one) dence 6 Other (Specify)
Records, P.O. Box 6	ling Physicien: The law requires that the death certifi h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	lting in the underlying cause given in Part 26. Place 27. Place 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M 28. Injury M M To Yes 2 Injury M To Yes To Ye	24a. Was autor performed to the control of the cont	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an Day Year Obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No Obacco No Obac
P.O. Box 6	ling Physicien: The law requires that the death certifi h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Manner of Death 1 Natural conditions of examiner? 2 Accident conditions of could not be determined.	Due to (or as a consequent of the consequent of	26. Place 26. Place 27. Place 28. Time of Injury Months, and the street, factory, office 1. Place	24a. Was autop performed to the control of the cont	Month Day Year obacco use contribute to the cause of death? fes 2 No 3 Probably 4 Unknown an say prior to completion of cause of death? 2 No 1 Yes 2 No dence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number, vn, State)
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Records, P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	26. Place 27. Place 28b. Time of Injury M 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at Work? My 1 Yes 2 Impersary at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a con and/or investigation, in my opinion, decorated at the time, date a constant	24a. Was autop performed to the coursed at the time, or the course of th	Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown an 24b. Were autopsy findings available prior to completion of cause of death? 22 No 1 Yes 2 No one) dence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number, wn, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
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			1 - For State Registrar	State of Ma	aryland	_	artment of H tificate of I		d Mental Hy	giene Reg. Ne	11115	15734
ı	Physici	an	Decedent's Name (First, Middle Pearl	_{e, Last)} Anna Willi	ams				2. Date of D Month April	Da	2005 Year	3. Time of Death 11:19 AM
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of D			County of Dear	
				Hospital			Lanham	1611-4041	U		rince G	
	Funeral Director		5. Social Security Number 192-07-5961	6. Sex 1 □ M 2 🗗 7. Ag	96 (In yrs. Ias	Yrs.	If Under 1 Year Months Days	If Under 24 I	Min. 8. Date of Bi (Month D April	ay, Year	08 Pen	hplace (State or Foreign nuntry) nsylvania
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	8a-f el	Director		George's	Rive	erdal					-	MXYes 2 ☐ No
	23a or 2	al Dire	10e. Street and Number 6620 Auburn A	venue			10f. Zip Code 20737	,		10g. Ci	tizen of What Co US	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Mardical Examinar must be indiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced	If Yes Give			Was Decedent of H If Yes, specify Cuba I ☐ Yes 2☐ No	ispanic Origin? in, Mexican, Pi Specify:	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:Bla	e, etc.
5-0	natur	etec		it's Education st grade completed)		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	working	16b. K	(ind of Business	Industry
7121	within iene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		eral Empl			U.S	. Gover	nment
nd	be filed Ital Hygi of other event, I	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	, Maider		
yla	2 should be and Mental is marked sumatic ev	은	George T. Smit			10b Mailie	a Address (Street		hine Kinr		Town State	Zin Co do l
	nd 2 si lith and 27 is r r traur		Joyce Richards						Riverdal			ip Code)
Baltimore,	of Health of Health if item 27 or other tra		20a. Method of Disposition X Burial 2 Cremation		20b. Plac	ce of Disponetery, crer	sition (Name of natory or other place	e)	Date		ocation - City or	Town, State
ţ	permit. Pages Depertment of Important: If it any injury or o		*4 □Donation 5 □ Other (S	Specify)	MD Na		Memorial				el, MD	
Bal	Depermine the permine the perm		21. Signature of Funeral Service	Allum	٠		_		Latney's		ngton,	Be 20611
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that caused only one cause on each li	the death.	Do not ent	er the mode of dyin	g, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Pn ysicia n /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Aspi		n					Onset and Death 1 Hour
	Examiner			Due to (or as Dysph		nce of):						! Month
	σ #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as			_					
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. Advance			ä. 					
68760,	ificate be executed g physician and as the burial-transit	edical E		d								
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ds, p	puires thet n signed b uld be deta	by P	Part II. Other significant conditi Hyperkalemia		ut not resulti	ing in the u	nderlying cause giv	en in Part I.		tobacco Yes X	_	the cause of death?
Division of Vital Records, P.O.	e la has	ompleted	Dehydration						24a. Waa auto peri 1 🗀 Yes		prior to death?	itopsy findings available completion of cause of
ital Marian		BeC	25. Was case referred to medica examiner?						Death (Check only			
%	Phys this al dii	٠ <u>.</u>	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 Inpatie		NOutpatier		4 🗀 Nursir	ng Home 5 Res			cify)
ion	Attending in death.	ation	1X Natural 5 ☐ Pendir	/Adminth Cla	y Year)	Injury	Wor	k? Yes 2 ☐ No			.,	
Divis	i or Atte after de: Directo	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 288. Place of inj	ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To			ural Route Number,
	To the Hospitei or Attending I within 24 hours after death. To the Funerei Director: After completely filled in by the funer	Medical C		ng Physician: To the best Examiner: On the basis o and manner st	f examinatio							
	To the within To the comple	Me	29b. Signature and title of certifie		-		29c. Licens	_			ite signed (Mont	_
	X		1	Cually I			D0042	2684		41	122/0	7
	1		Jay Zwally, I	who completed cause of cause of	leath (Item 2 Iain S	3a) (Type. treet	Print) Suite	351, La	urel, MD	2070	07	
	Sta Registr		31. Date filed (Month, Pay, Year	2005 33 Registr						-		

			For State Registrar	tate of Maryland / Depa Cei	artment of Health and M rtificate of Death	lental Hygie	2000	15735
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Vara	3. Time of Death
	Physicia		Mary	C.	White	Month MAY	Day 2005	4:45 AM
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of Death		4c. County of Death	
			ST. AGNES HE	ALTHCARE	BALTIMOR	E		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign
	Director		213-30-3276	2⊠F 71 Yrs.		07 23		MD
	and W	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	Od. Inside City Limits
	f eho	5	,		nsville			1 ☐ Yes 2 ▼ No
	28e-1	Director	MD Baltimo 10e. Street and Number	Le Cator	10f. Zip Code	10a	. Citizen of What Cour	ntry?
	with Be or			a I and Ant 326	21228		U.S.A	
	leath	Funeral	303 Maiden Choic	Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
'	r iter	표		1 ☐ Yes 24 TvNo		Rican, etc.)	Black, White,	etc.
93	al', o	þ	3 Widowed 4 Divorced	If Yes, Give 122 Year or Dates:	1 ☐ Yes XXNo Specify:		Specify: B	lack
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or iteme 23a or 28e-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Educati (Specify only highest grade co		dent's Usual Occupation kind of work done during most of work	ing 16	b. Kind of Business/In	dustry
2	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		Padio 1	Station
	e filed within al Hyglene. I other than ' vent, the Me	Co	12th grade	1+ Ra	dio Personality			Station
E L	be fill d oth	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
yla	2 should be f and Mental H Is marked of reumatic eve	유	James Matthews_	000 Maril	Eleanor ng Address (Street and Number or Run	Thornt		Codel
Maryland	12 sh h and 7 Is n treun		19a. Informant's Name/Relationship (Type,		•	-		
ď,	s 1 and 2 should if Health and Mer Item 27 Is marks other treumatic		Mark Clayburn-Sc 20a. Method of Disposition	20b. Place of Dispo			c. Location - City or To	
jo L	ages nt of t: If it		X\sumber Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	oval from State	Memorial Park	5/9/05	Arbutus.	mд
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.	l i	21. Signature of Funeral Service Licensee	2	2. Name and Address of Facility	3/3/00	ALDUCUS,	ilid
8	permi Depar Impo any ir		Somitte	K. Inner	arch F/H West 300 Wabash Ave,	Baltim	ore. Md	21215
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death. Do not en				Approximate Interval Between
1	Fnysician		Immediate Cause (Final		PLE MYELDI	ma		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	11110201			MIUMIAS
н	Examiner		Sequentially list conditions b.				1	
	p ==	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	The law requires that the death certiticate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Examiner	that initiated events c	Due to (or as a consequence of):				
8760,	be ex icien a	<u>=</u>		Due to (or as a consequence or).				
87	cate physi	dlcal	d					
9 ×	ding se as	/Me	IF FEMALE: 23c.	If yes, outcome of pregnancy			23d. Date of deliv	erv
Вох	that the death certitics ed by the ettending ph detached for use as t	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	the d y the iched	lsk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	0041W66			
	res that signed b	by Pł	Part II. Other significant conditions contrib	buting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
rds	quires n sig uld be	g p	END STAGE	RENAL DISEX	4SE	1 ☐ Yes	2 2 N o 3 □ Prol	bably 4 Unknown
Records,	aw requir s been si s should I	Completed				24a. Was an autopsy	24b. Were auto	opsy findings available
Re	The ta te ha	E				performe		mpletion of cause of
Vital		0	25. Was case referred to medical		26. Place of Deal	h (Check only one)		
of V	> 20 0	To B	examiner? 1 ☐ Yes 2 ☐ No Hos	pital: 1 ☑Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residenc	ce 6 □Other (Speci	fy)
0	ding Pt	ino ino	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year)	Work?	28d. Describe how	injury occurred	
Sio	Attending in death. ector: After by the tune	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No	OOK I anation (Ctm.	at and Alumbas as Due	al Davida Alverbas
Division	or At Itter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town,	et and Number or Run State)	ar moute Number,
	pltel		29a, Certifier 1 Certifying Physic	an: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the caus	se(s) and manner as s	stated.
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director: Atter th completely tilled in by the tuneral	Medical		On the basis of examination and/or in	rvestigation, in my opinion, death occur	red at the time, date	and place, and due t	o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	490	29c. License number	29d	I. Date signed (Month,	Day, Year)
	4		1 Si	bun DR.	P-18916	1	MAY, 4,	2005
^			30. Name and address of person who comp	pleted cause of death (Item 23a) (Type	, Print)		\$4.55 FEE	0.15
	U		ISMAILA JIBRIN	1, ST. AGNES +	HEALTHCARE, 91	DDS. CA	IDN AVE.	BALTIMORE
		ate	31. Date filed (Month, Day, Year) 0 200	5 32 Degistrar's Signatur	29c. License number $P - 18916$ Print) $P = P + P + P + P + P + P + P + P + P + $			
	Regist	rair	*******	The second of				

		I.	Williams Please unpend item#23a,	Type or P State of	rint in 1 Marylar	Black In	delib artme	le Ink. nt of H	Ens i	u <mark>re Al</mark> and M	I Copie: lental Hy	s Are	e Legible).	2700
DO	5	•	1 - State Registrar			Ce	rtifica	ite of L	Death	7		Reg. N	<u>6.</u> U U 3		3/36
	Physici		1. Decedent's Name (First, Middle, Las Decarlos I. Wil	·							2. Date of D Month April		2005	~	Time of Death 655 p M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death 4c. County of D							eath		
9			Prince Georges Ho	~			Mila		never				Prince	Geor	ges
2	Funeral Director		5. Social Security Number UNK 6. Si	9X 7. ▼M 2□F	Age (In yrs.	Yrs.	Month	er 1 Year s Days	Hours	Min.	8. Date of B (Month, D Februa	irth ay, Yea ary	28,198	Birthplace Country) 4 Wa	State or Foreign
B	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cîr	ty, Town or L	ocation							10d.	Inside City Limits
	Maryli 1 sho	ior	Maryland Prince	George	III	per Ma	r1ha	ro							1 ☐ Yes 2 ☐ No
	the reserve	rec	10e. Street and Number	-	- OF	per in		Zip Code				10g. (Citizen of What		
	h with	ai D	10902 Waharton Dr	ive				20774	+			Un	ited S	taes	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, Ite Marginal Examinational Legical Angles and Angles.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? M No	.S. 13.		edent of Hi becify Cuba 28114No	ispanic O n, Mexica Specify		ecify Yes or N Rican, etc.)	lo-	14. Race - A Black, V Specify: B	/hite, etc.	ndian,
Õ	72 ho	ted	15. Decedent's Ed (Specify only highest gra	fucation		16a. Dece	edent's Us	sual Occupa	ation	et of work	ina	16b.	Kind of Busine	ss/Indust	ry
21215-0036	within 7 ene. than "t	mple	Elementary/Secondary (0-12) Tenth	College (1-4	for 5+)	Never		vork done o use retired ked) ')	or or more	,,,,g	N	one		
	filed Hygi other ent, I	Φ	17. Father's Name (First, Middle, Last)			1.000		1100	18. Moth	ner's Name	e (First, Middl				
lan	fental fental rked tic ev	To B	Steven Allen Wil	liams					Ele	nor l	Depree				
Maryland	shou and N s mai	Г	19a. Informant's Name/Relationship (Type, Print)		19b. Mail	ing Addre	ss (Street a				ber, City	or Town, Star	e, Zip Cod	de)
	and 2 eaith n 27		Diane White/Aunt												nd 20774
Baltimore,	ges 1 of Hi if iter or off		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from St		Place of Disp cemetery, cre					2005		Location - City		
ţ	tment: tent: ijury		`4 Donation 5 Other (Specify		Ne						L 16,		exandri on Fune		irginia
Bal	Department Department		21. Signature of Funeral Service Lice	- 10 1	~ 11 i i								on rune gtonDC		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	cations that car	ollii used the dear	th. Do not er	nter the m	ode of dying	g, such a	s cardiac	or respiratory	arrest,	gconso	Ap	proximate
	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Acuto Due to (o	Asth ras a consec ras a consec	na quence of):								Ön	erval Between set and Death
	cuted od ransit	Examiner	that initiated events	C											
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rds, P	w requires that been signed should be del	ed by P	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the	underlyin	g cause give	en in Part	1.			o use contribut 2□No 3□		,
Il Records,	The law ate has b page 2 st	Completed									24a. Wa auto pen 12 Yes	opsy formed?	prior deat	to comple n?	findings available etion of cause of No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	or.		h (Check only				388- 38-
ion of Vital	ding Phys	ation: To	1X Yes 2 No 27. Manner of Death 1XX atural 5 Pending investigation	28a. Date of (Month)	patient 2 Injury , Day Year)	28b. Time (Injury		28c. Injury Work	4 🗀 1		me 5 Res 28d. Describe		6 □Other (5 ju ry occurred	Specify)	
Division	or Dire	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place 0	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, s	treet, fact	ory, office			28f. Location City or To	(Street own, Sta	and Number o. ate)	r Rural Ro	ute Number,
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	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	0 -			2	29c. License					Date signed (M		, Year)
	KIND		Theoder U	1es		2		OCME				Apr	il 10,	2005	
7	P		30. Name and address of person who	completed carre	of death (Ite	m 23a) (Type	, Print)	111	Donn	Ctro	oot D-	1+4-	mores 1	low-1	and 01001
		to	31. Date filed (Month, Day, Year)	32. Re	distrar's Sign	ature #_	p. Committee of the com	TTT	r em	DILLE	eer Da	IT L L	more, M	агута	and 21201
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		. Decedent's Name (First	, Middle,	Last)								2. Date of D	eath	ay	Yeer	3. Time of Dea
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State

Registrar

MAY 1 0 2005

GILBERT BOURJEILY SGOT WITH RAVEN BLVD BALTIMORE MDZ1239

31. Date filed (Month, Day, Year)

32. Registrar's Agnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear 12:14 AM WILSON 2005 MARK ALLAN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A BALTIMORE CITY GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03/04/1950 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number NEW YORK 1**∑**M 2□ F Months 55 218-54-3763 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County BALTIMORE CITY XXYes 2 □ No N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21212 USA COLDSPRING LANE 720 E. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DIETARY GOOD SAMARITAN Elementary/Secondary (0-12) College (1-4or 5+) COOK 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARGARET L. JONES WILLIAM R. WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3719 RIDGECROFT ROAD, BALTIMORE, MD 21206 CYNTHIA DAVIS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State METRO CREMATORY 5/4/2005 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Licensee HOWELL FUNERAL HOME 21207 HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause (Final yardiline). 4600 LIBERTY Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence Heure Due to (or as a consequence of):

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

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other than

27 is marked or traumatic ev

Department of Health a Important: If itam 27 is any injury or other trains once.

Director

Funeral

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Completed

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this After Diractor:

The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

Hospital or Attending Physician:

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within 24 hours a To the Funeral D

IF FEMALE 23b. Was decedent pregnant in the past 12 months? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

Examiner Physician/Medical þ Completed Be (P Certification: 29a. Certifier Medical

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

1 @Inpatient

3 Ectopic pregnancy 5 Other (specify)

Day Year 23e. Did tobacco use contribute to the cause of death?

1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an

23d. Date of delivery

autopsy performed? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2DINO 1 Yes

2005

1 Natural 2 Accident	5 Pending investigation	(Month, Day Year)	Injury	М
3 Suicide	6 Could not be determined	28e. Place of Injury - At h	ome, farm, stree	et, factory, of

Hospital:

Injury at Work? 1 ☐ Yes 2 ☐ No fice

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and Hile of certifier

29c. License number

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lock Raven Blud. Baltimere, MD 21239 Hassan 5601

31. Date filed (Month, Day, Year) State

(Check only one)

32. Registrar's agnature MAY 1 0 2005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

			1 - State of Maryland / Departr State of Maryland / Departr Francisco	nent of Health and Me as icate of Death	ental Hygien	2005 5739
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ELAINE WEBB	1	2. Date of Death Month Da	
	Examin			BALTINORE,	~ →	c. County of Death N/A
	Funeral Director		215-18-6339 1 M 2X F 81 Yrs. MC	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	B. Date of Birth (Month, Day, Year 06/03/19	
	Aaryland F show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALT	IMORE CITY		10d. Inside City Limits 1 Yes 2 □ No
	with the N e or 28e-	Director	10e. Street and Number 1	Of. Zip Code		itizen of What Country?
36	ges 1 and 2 should be filled within 72 hours after death with the Maryland it of Health and Menfal Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Examinations in Items at the Intiffed at	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	21216 Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto R Yes 2X No Specify:	ify Yes or No- ican, etc.)	SA 14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 hour ene. than "natural' ne Medical Ex	Completed by	(Specify only highest grade completed) (Give kind life. DO N	's Usual Occupation I of work done during most of working NOT use retired)	g 16b. I	Kind of Business/Industry
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Maryland	2 should b and Menfa Is marked eumatic e	Tof	EDWARD BOOKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Advanced in the control of the co	EMEL ddress (Street and Number or Rural		IMINGS or Town, State, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ Removal from State 1 ♣ Donation 5 □ Other (Specify)	CEM. 5/13	/05 BA	LTIMORE CO., MD
Balt	permif. Page Department Importent: If any injury o		1/ When 1 . I seeks 460	00 LIBERTY HEI	GHTS AVE	RAL HOME 21207
	Physician /Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	ne mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transif	dical Examiner	if any, leading to immediate cause in the truth of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
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Il Record	The ate h page	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? o 1 ☐ Yes 2 ☐ No
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death		6 ☐Other (Specify)
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Division	el or Atte s after des il Directo od in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28	Bf. Location (Street a City or Town, Star	ind Number or Rural Route Number, te)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigation and manner stated.	curred at the time, date and place, ar igation, in my opinion, death occurred	nd due to the cause(: d at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)
)	Tot withi Tot	×	29b. Signature and title of certifier Mokene, MD	29c. License number 3 8009		ate signed (Month, Day, Year)
. 1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin ZELALEM MAKONNEN 5601 LOCH	RAVEN BLUD.	BALTIN	10RE, MD 21239
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2005	fores		

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			1 - For State Registrar	Otato of W	arytana /		rtificate			Meritarriy	Reg. No		<i>)</i> 1	0 1 1	
	Physici	an	1. Decedent's Name (First, Middle, L	,						2. Date of De			Year _	3. Time of	
	/Medi	cal	Ann Elizabet 4a Facility Name (If not institution, gi				4h Cib. T	·	A service of Dec	May	1	2	205	0816	MM
1	Examir	ier	St. Panes H	eathco	ne		Ba	I ti	Location of Dea	lin .	40	. County o	r Death		
	Funeral		, , , , , , , , , , , , , , , , , , ,	Sex 7. Ag	ge (In yrs. last b	irthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hr Hours Mir		th ay, Year)		9. Birthpla Count	ace (State or	Foreign
ŀ	Director		215-18-7144 Usual Residence of Decedent		_83	113.				March	9,19	22	Wash:	ington	D.C.
	arylan show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation					-	10	d. Inside City	
	the Mi	Director	Maryland Howard 10e. Street and Number		E11	icot	t Cit				10- 04			1 Tes	
	3e or	E D	3357 Apt A North	Chatham R	oad			.042			US ₂	izen of Wi	nat Count	ry?	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23e or 28a-f show other treumatic event. The Martical Eventines in the rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Amed Forces' 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	1		ent of His fy Cuban		Specify Yes or No nto Rican, etc.)		14. Race	, White, e	tc.	
5-0	72 ho	eted	15. Decedent's 8 (Specify only highest gi	ducation rade completed)	16	a. Deced	lent's Usual kind of work	Occupa	tion uring most of wa	orkina	16b. K	ind of Bus	iness/Ind	ustry	
121	within ene.	Completed by	Elementary/Secondary (0-12)	College (1-4or			<i>00 NOT</i> use etary	e retired)	uring most of wo		M	edica	1		
d 2	e filed with Il Hygiene. other thar vent, the N	Be Co	17. Father's Name (First, Middle, Las	t)			- Call. y		18. Mother's Na	ıme (First, Middle					
ylar	should be and Mental s marked o umatic eve	To E	Herman Sartoff						Margar	et Exley	7				
Mar	d 2 sho		19a. Informant's Name/Relationship Joseph Waddell	(Type, Print) Husb						tural Route Numb :ham Road					2107
	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition		20b Place	of Disno		e of		Date ROAC		cation - C			21042
Baltimore,	0 0		1 ☐ Burial 2 ☒ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	ify)		Wasł	ı.Crem	ator	cy 5/5/	²⁰⁰⁵ 1	aur	e1, M	ary1	and	
Bal	permit. Pag Department Importent: f eny injury o		21. Signature of Ineral Sender Live	ansa y	-7	22	Sterl 736 E	ing	Ashton	Schwab E	uneı	al H	ome,	Inc.	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each li	d the death. Do	not ent	er the mode	of dying	, such as cardia	c or respiratory a	rrest,			Approximate Interval Betw	reen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ov Ov Due to (or as	a consequence	1087	YUC	カレ	e w	ing Bi	800	X		Onset and De	'ars
В	Examiner	_	Sequentially list conditions, if any, leading to immediate	b					1.00						
	ited Insit	Examine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):									
ó	certificate be executed of the physician and ise as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):									
68760,	icate be physici s the bu	Medical		d											
O. Box 6	death e atter id for L	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pred					23d. Date Monti			ear
0	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the ur	iderlying cau	use giver	n in Part I.	23e. Did to	obacco u	se contrib	ute to the	cause of de	ath?
ord	w require been sk									1 🗆 🕆	/es 2	□No 3	☐ Probal	bly 4 Ur	iknown
Vital Records,	The law ate has b page 2 si	Completed								24a. Was autop perfo 1 🗆 Yes	sy /	pride	or to comp ath?	sy findings av pletion of cau	vailable use of
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatie	ent 2□ER/O	utnation	3 □ DOA	Other		ath <i>(Check only</i> o Home 5□ Resid		Other	(Consit i)		
Division of	ding h. After fune	atlon: T	27. Manner of Death 1 Patural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury		c. Injury a Work?	at	28d. Describe				1101	
Divis	i i i i i	Certification:	3 Suicide 6 Could not to determined		ury - At home, f. c. (Specify)	arm, stre	et, factory,	office		28f. Location (5 City or Tow	Street and In, State	d Number)	or Rural I	Route Numbe	ə <i>r</i> ,
	ne Hospitel of 24 hours a ne Funerel E	edical	29a. Certifier 1 Certifying P. (Check only one)	hysician: To the best miner: On the basis o and manner st	r examination at	e, death nd/or inv	occurred at estigation, in	the time	e, date and place nion, death occi	e, and due to the curred at the time,	ause(s) date and	and mann place, and	er as stat d due to t	ed. he cause(s)	
9)	To the within 2 To the complet	Me	29b. Signature and title of certifier	٨			29c.	License	number		29d. Dat	e signed (Month, Da	ay, Year)	
,	6		Daniel	& mr)		P	18	404		5	121	05)	
0		-1111	30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, I	OOC	att	on P	ve. Bo	Ita	. m	02	422	9
	Sta Registr	_	31. Date filed (Month, Day, Year)	1 0 2005 Regist	's Signature	J.S.	1900								

Ohn E. Waddell

				For State Registrar	State o	f Marylan		artment rtificate			Mental Hy	giene Reg. No.) () 5	1574	
		0		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	aath Day	Year	3. Time of Deat	th
		Physici /Medic		Marjorie E.							May	4	2005	0219	М
		Examir		4a. Facility Name (If not institution,		,		4b. City, T	own, or Loc	cation of Death	1	4c. 0	County of Death		
				Gilchrist Medic			In at hirthday	If Under 1	owson	Under 24 Hrs.	O Date of Bi	dh	Baltin		raign
		Funeral Director		5. Social Security Number 219–22–2030	5. Sex 1 ☐ M 2 🔼 F	7. Age (In yrs. 83	ras <i>t birthday)</i> Yrs.	Months		lours Min.	8. Date of Bi (Month, Date of Bi (Oct. 2	ay, Year) 2 102	1 Mary	lace (State or For	eign
				Usual Residence of Decedent							JUCE . 2	J 9 I 7 Z	I mary.	Land	
		ylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Lir	
		Ba-fs	Funeral Director	Maryland Balt	imore		Cat	onsvil	1e					1 □ Yes 2 🔀	INO .
- 5		ith th or 28	Dire	10e. Street and Number				10f. Zip (Code			10g. Citiz	en of What Cour	itry?	
5		ath w	rai	1310 Ridge			- 1		212				U.S.		
0		ltems	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Fo		.5. 13.	Was Decede If Yes, specif	fy Cuban, N	nic Origin? (S Nexican, Puert	pecify Yes or No o Rican, etc.)	0-	Black, White,		
90	36	irs afi	by F	3 ₩ Widowed 4 Divorced	If Yes, Gr Year or D	ve		1 Yes 2	⊠ No S	ipecify:			Specify: Wh	ite	
120	21215-0036	be filed within 72 hours after death with the Maryland hat hygiene. ad other then "neturel", or Items 23e or 28e-f show event, the Medical Exartrant retribited at	ted	15. Decedent's			16a. Dece	dent's Usual	Occupation	n ng most of woi	rking	16b. Kin	d of Business/In	dustry	
4	218	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)	ig most of wor	Kiiry				
Z		e filed within al Hygiene. i other then " vent, the Me	Con		4			Homema		**	(F) . A(1)		n Home		
	nd	be fill Hold of he	Be	17. Father's Name (First, Middle, L					18		me (First, Middle M. Sch		iumame)		
F	Maryland	2 should be and Mental is marked of sumatic even	2	John D. Rupper 19a. Informant's Name/Relationsh			10h Maili	na Address	/Street and				Town, State, Zip	Codel	
3	Ma	d 2 si th an th an treur	19	James Wharton	(Son)		1				owson, l			0000)	
Varjone Wharton May 4, 2005 0219,	<u>a</u>	es 1 and 2 should of Health and Mer I item 27 is marker rother treumatic		20a. Method of Disposition	(BOII)	20b. F	Place of Dispo			chac 1	Date .		ation - City or To	own, State	
Ce	Baltimore,	0 0		1 ⊠ Burial 2 ☐ Cremation 1 ☑ Burial 2 ☐ Cremation		State				y	-2005	Pike	sville.	Marylan	đ
80	量	permit. Page Department Importent: If eny injury o		21. Signature of Euneral Service L		1 1	2	2. Name and	Address o	f Facility	200000000000000000000000000000000000000				-
ar	m			Deman	* Lal	mede		itzke 630 Ed	monds	on Ave	e or Car nue Cat	onsvi	ille, Ir lle, MD	21228	
				23a. Part1. Enter the disease, or of shock, or heart failure. List of	nly one cause on	caused the deat								Approximate Interval Between	1
4		Physician		Immediate Cause (Final disease or condition	. PA	raced	اند ا	caner						Onset and Death	
		/Medical Examiner		resulting in death)	Due to	(or as a consec	uence of):								
		LAGITITICI	<u>.</u>	Sequentially list conditions,	b. Due to	(or as a consec	neuce off-								
		ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Q	(0. 40 4 00.1000	30.100 01).								
	,	execut n and ial-trar	Exal	that initiated events resulting in death) Last	c	(or as a consec	uence of):								
	Box 68760,	ate be executed ysician and he burial-transit	icai		d										
	68	rtifica ng ph as th		IF FEMALE:									1		
	30X	leath certific attending pi	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnation in the pregnation of the pre	I death 3	Ectopic pre				2	3d. Date of delive Month	ery Day Year	
		the at	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of o nown	leath 5 [Other (spe	ecify)					,	
	P.O.	es that the d gned by the be detached		Part II. Other significant condition	ns contributing to o	leath but not res	sulting in the u	ınderlying ca	use given i	n Part I.	23e. Did	tobacco us	e contribute to the	he cause of death	?
	ds,	uires n signi ld be	d by								1 🗆	Yes 2	Ø o 3□ Prot	pably 4 Unkn	own
	00	w requir been si should	lete								24a. Wa		24b. Were auto	ppsy findings avail	able
	Re	The lavate has	Completed	-							auto perf	ormed? 2 No	prior to co death? 1 ☐ Yes	mpletion of cause	10
	ital	i cien : Th certificate rector, pag	a a	25. Was case referred to medical					26	6. Place of De	ath (Check only	— <i>!</i>	- 100	20.10	
	f V	ysicien: nis certific director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatie				Home 5□Res	idence 6	ther (Special	n hospic	e
	n 0	ding Ph h. After thi funeral		27. Menner of Death 1 Natural 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		Bc. Injury at Work?		28d. Describe	how injury	ccurred		
	sio	death. ctor: Al	cati	2 Accident investig	et ho			M		2 □ No	20f Leasting	(Ctrant and	Alumbas as Dur	al Route Number,	
	Division of Vital Records,	Jor Att after de Direct	Certification:	4 Homicide determi		e of Injury · At h ling, etc. <i>(Speci</i>		reet, ractory,	, опісе			wn, State)	Walliber of Auto	ii noute Number,	
	_	urs urs aral		29a. Certifier 1 Certifying	Physician: To th	e best of my kn	owledge, dea	th occurred a	at the time,	date and place	e, and due to the	cause(s)	and manner as s	tated.	
		To the Hosp within 24 ho To the Fund completely f	edicai	(Check only 2 Medical E	xaminer: On the l and mar	pasis of examination of the state of the sta	ation and/or in	nvestigation,	in my opini	on, death occi	urred at the time	, date and	place, and due to	the cause(s)	
		To the within 2 To the comple	×	29b. Signature and title of certifier	1 1			29c.	License no	umber			signed (Month,		
		-7		The Co	mo	>			リらて	350%		MAY	4 200	7	
	1.	2'		30. Name and address of person v	who completed cau	se of death (Ite	1 23a) Type	Print)	ST	Barn	rose a	021	204		
		- 61	oto	31. Date filed (Month, Day, Year)	32.1	Registr: s Sign	ature 1				with the	-	1		
		St Regist	ate trar	MAN	1 0 2005	Honey	w 10.	Spa	-						

DHMH 17 Rev 1/2001

	√N 05-31 n W. Whe		Please Please Please Please	Type or Print in E State of Marylan 23a,27,28a-f			•	_	15742
	a w wiic				Certific	cate of Death			
	Physici /Medi		1. Decedent's Name (First, Middle, La	CEHW BUKA			2. Date of Dea MAY 6,	2005 Year	3. Time of Death
2	Examir	ner	4a. Facility Name (If not institution, giv FALLS ROAD & IVY			City, Town, or Location of CKEYSVILLE	f Death	4c. County of Death	
9	Funeral	•	5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday) If L	Inder 1 Year If Under 2		BALTIMORE 9. Birth	nplace (State or Foreign untry)
33	Director		3\2 04 3\50 Usual Residence of Decedent	nds M 2□F a\	Yrs. Mo	nths Days Hours	Min. (Month, Da		RULAND
	death with the Maryland rms 23e or 28e-f show	tor	10a. State 10b. County Massland Hasses		y, Town or Location				10d. Inside City Limits 1 ☐ Yes 🍇 No
	or 28e	Director	10e. Street and Number		12011	f. Zip Code		10g. Citizen of What Co	untry?
	Jeath with	eral	2925 HOY KOA		0 10 110 110	31133		D.S.A	To a la diag
10	ter dea r tems	Funeral	11. Marital Status 1 ☐ Never Married 2⊈ Married	12. Was Decedent Ever in U. Armed Forces? 1 ♥ Yes 2 □ No	.S. 13. Was I	ecedent of Hispanic Orig specify Cuban, Mexican,	In? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	filed within 72 hours after Hygiene. ither then "natural", or Ite ant, 'he Wed'eal Exemm	by	3 Widowed 4 Divorced	1 A Yes 2 □ No If Yes, Give Year or Dates:	1 🗆 Y	es 2 No Specify:		Specify: W	HITE
5-0	72 hours natural;	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's	Usual Occupation of work done during most OT use retired)	of working	16b. Kind of Business/l	ndustry
121	within ane. then	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)		7 7 7	
9	filed v Hygie other f	e Co	12 PS - 17. Father's Name (First, Middle, Last	778	POKKL.	18. Mother	's Name (First, Middle,	Maiden Sumame)	*
an	lid be ental kad o ic eve	To Be	William 12	selection -	50	16	ALRA A	I ENERHII	1-50
ary	should and Men s marka	-	19a. Informant's Name/Relationship (19b. Mailing Ad	dress (Street and Number	or Rural Route Numbe	or, City or Town, State, Z	ip Code)
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'any injury or othar traumatic evant, the Mannes.		REGERA A. WH	IIIIR	3932 (YOUR BORD FOR	34,45x1V	MAYENAM	31133
ore	of He of He If item or oth		20a. Method of Disposition 1 Burial 25 Cremation 3	Removal from State 5.00	Place of Disposition	(Name of or other place).	IRY 8	Oc. Location - City or	
Ë	Pages tment of I tant: If its jury or o		`4 ☐ Donation 5 ☐ Other (Spedil		cemetery cremator			FOREST HILL	MARILAND
Baltimore,	permit. Departr Importa any inj		21. Jig satura of Fungial Sattle Lice	Y-96	22. Nan S V A	ne and Address of Facility	EHADEL-B	ZIATR P.A	
_	40360		330 Port Enter the disease or seed	diabilities that assessed the dest				HIT WAS	ALAMO
	20		23a. Part1. Enter the disease, or confishock, or heart failure. List only Immediate Cause (Final	-				rest,	Approximate Interval Between Onset and Death
	Prysician /Medical		disease or condition resulting in death)	a. Thermal inju		soot inhala	ition		
	Examiner			Due to (or as a conseq	uence or,				
, .		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):				
A	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	C.					
60,	be exe icien a burial-	al Ex	resulting in death) Last	Due to (or as a consequence	uence of):				
	cate b			d					Y
Вох 687	certifi ding I se as	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy			204 Date of dall	Y-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
Bo	The law requires that the death certificate in the has been signed by the atlending physionage 2 should be detached for use as the b	by Physiclan/Medlc	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	Ideath 3□Ecto	pic pregnancy or (specify)		23d. Date of deli-	very Day Year
P.O.	the c by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		, , , , , , , , , , , , , , , , , , , ,			
	w requires that the deben signed by the should be detached	y P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underly	ing cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	en sig						1 🗆 Y	es 2□No 3□Pro	bably 4 Unknown
000	law re as be 2 sho	Completed					24a. Was a		opsy findings available ompletion of cause of
Œ.		Som					perfor		
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?				of Death (Check only or		
of	Physi this c	2	1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2		DOA Other: 4 Nur	sing Home 5 Resid	lence 6 X Other (Spec	(fy) SCENE
no	ftel ne	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Fourid At	28c. Injury at Work?	Driver o	n may motor v ixed object	ehicle that s and caugh
Division of Vital Records,	Attanding r death. actor: After yy the fune	flca	2 Accident investigation 3 Suicide 6 Could not b	5-6-05	3:04 A	1 ☐ Yes 2 🛣 N	fire		
ă	al or / s after f Dira d in b	erti	4 Homicide	building, etc. (Specify Road	y)	,,	Roads Co	Treet and Number or Runn, State) Falls &	L LVY HILL
(1)	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification;	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exar	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occu tion and/or investig	rred at the time, date and ation, in my opinion, death	place, and due to the o	ause(s) and manner as	stated. to the cause(s)
_	To the within Fo the comple	Me	29b. Signature and title of certifier			29c. License number	2	29d. Date signed (Month	, Day, Year)
	C 3 F 0		I him hi	, m.D		OCME		MAY 6, 20	05
			30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)				
			LING LE,	mio		111 Penn Sti	reet Balti	more, Maryl	and 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture				
	Registr	ar	MAY 1 0 2	2005	H Loc	E			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Alberta Wyatt 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GOOD SAMARITAN DALTIMORE 405PITAL | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, MAR 14, 10 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Months 88 124-16-6179 Director New Jersey Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insportment of Health and Mental Hygiene. Insportment if item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 DYes 2 No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6225 York Road Apt. N305 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █\No Black Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Hospital 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wyatt Annabell Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Littleton Wyatt/cousin 1005 Withers oon Road Baltimore, MD 21212 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 5/9/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. Dava M. McDonald Mucl 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROBABLE Physician MYOCARDIAL disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 21 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗀 No 1 Tyes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLUD HORTECKAW 1110 31. Date filed (Month, Day, Year) MAY 1 0 2 32. Registrar's Signature 1 0 2005 Registrar

05-3037 B.K.S GARY B. WILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland	Department of Health an	d Mental Hygiefie		Luc
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			1 - For State Registrar	otate of warytan	Cei	rtificate of l	Death	iontai i ij	Reg. No.	U J	10/44
	Physici /Medi		1. Decedent's Name (First, Middle, Last, $Gary \qquad B_{ \bullet}$	Williams				2. Date of De Month MAY 2	Day 2,2005	Year	3. Time of Death 0820 A
	Examir		4a. Facility Name (If not institution, give : 105 SOUTH ROCHEST				Location of Death		4c. Cou	unty of Death	
	Funeral Director		5. Social Security Number 6. Set 216–50–8392 Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. Jan. 5	rth ay, Year) , 1949	9. Birth Coul Ma	place (State or Foreig intry) iryland
	Maryland 8-f ehow	tor	10a. State 10b. County Maryland	10c. City	y, Town or Lo	cation timore Ci	.ty				10d. Inside City Limits
	h with the 23e or 28	Funerai Director	10e. Street and Number 105 Rochester Pla	ce, South		10f. Zip Code 21224			•	of What Could	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f ehow any injury or other traumatic event, I'rs M. dical Ex. min. civilat be invitible at ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		ecity Yes or N Rican, etc.)		Race - Americ Black, White, acify: Wh	
Baltimore, Maryland 21215-0036	t within 72 ho piene. r then "natur ine wedical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupi kind of work done o DO NOT use retired	during most of work)	ing		of Business/In	,
and	I be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last) Del1 William				18. Mother's Name		, Maiden Sun		
Maryl	nd 2 should be f Ith and Mental I 27 is marked or traumatic eve	P	19a. Informant's Name/Relationship (Ty Denise Williams	pe, Print)		ng Address <i>(Street a</i>			er, City or To		-
more,	Pages 1 an ent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place ark Cremato	ө)	Date		on - City or To	own, State
Balti	permit. I Departm Importa any inju		21. Signature of Fundal Pervice Census		22	2. Name and Address 221 Grayb	s of Facility Har	rman Fu	neral	Servic	e, P.A.
	Prysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consequ	notic uence of):	er the mode of dyin		Section	-		Approximate Interval Between Onset and Death
Box 68760,	aath certificate be executed attending physician and for use as the burial-transit	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequent of the consequent of	ncy death 3	Ectopic pregnancy			23d.	Date of delive	ery Day Year
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Division of Vital	To the Hospitel or Attending Physician: Within 24 hours after death. To the Funerel Director: After this certifical completely illied in by the funeral director,		27. Manner of Death XX Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at :? ∕es 2 □ No	28d. Describe			
N N	itel or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rura	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time vestigation, in my op	e, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and date and place	manner as st e, and due to	tated. the cause(s)
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	Sta	te	30. Name and address of Jerson who co	mpleted cause of fault (Item 111 Registrar's Signal	PENN	STREET, E	BALTIMORE	,MARYLA	ND 212	01	

Registrar

MAY 1 0 2005

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ORIGINAL

			1 - For State Registrar	State of Ma	aryland		artment of F tificate of				iene	05		745
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	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under 1 Year	If Under :		8. Date of Birth	Vans	9. Birthp	lace (State	or Foreign
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3	al', o	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Specif	ƴ: Whi	te	
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ב	urs af													
	To the Hospital or Atlanding Physician: The within 24 hours alter death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical	29a. Certifier (Check only one) Certifying Physici 2 ☐ Medical Examiner	: On the basis of	examinatio	n and/or inv	estigation, in my or	pinion, death	occurre	d at the time, dat	e and place.	and due to	ited. the cause(s)
	thin the other comple	Mec	29b. Signature and title of certifier	and manner sta	nted.		29c License	e number		296	d. Date signe	1 (Month F		
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	Λ	9	30. Name and address of person to comp	leted se t de	o (Itam 2	Call	1219 /	17		3	4 03			
)	29b. Signature and title of certifier 30. Name and address of person o comp N. L. C. L. J. J. H. B. J. 31. Date filed (Month, Day, Year)	mc 49	40 1	MILEN	Ave 1	PALTI	MZ	r md	2/7-	24		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	r's Signatur	re R	A. J.	, ,		,	سية "			
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Willrams, Del Mathlan

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		•	For State Registrar	,		tificate of		_	Reg. No.	000	13/40
	Physici		1. Decedent's Name (First, Middle, Last) Delnathan Will	iams				2. Date of De Month	path Day	Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of Death		4c.	County of Dea	
			5. Nai Hospital 5. Social Security Number 6. Sex	of Bult	Truo re	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	N/.	A thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 246-60-5539		63 Yrs.	Months Days		(Month, Da	ay, Year)	Co	N. Carolina
	ס	Ì	Usual Residence of Decedent 10a. State 10b. County	100 Cib	y, Town or Lo	cation		Sept.	1-3-7	1941	10d. Inside City Limits
	e Maryla la-f shov Uffied at	ctor	Maryland N/A	Toc. Oil		timore					1 ∑ Yes 2 □ No
	vith th	Funeral Director	10e. Street and Number	- #203		10f. Zip Code 2121	_		10g. Citi	zen of What Co ≳ ∆	ountry?
	eath v	erai	6624 Eberle Driv	Yas Decedent Ever in U.	S. 13.		Hispanic Origin? (S	pecify Yes or No		14. Race - Ame	erican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Entities fraumatic and once.	Ď	1 Never Married 2 Married 1	rmed Forces? ☐ Yes 2 ☑ No i Yes, Give 'ear or Dates:		f Yes, specify Cub 1 ☐ Yes 2 🛣 No	oan, Mexican, Puert	o Rican, etc.)		Black, White Specify: B	
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Maryland	12 should be fi h and Mental H 7 is marked ot fraumatic ever	To	Ernest Williams,					Benne			
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, F Beatrice Williams		19b. Mailir	ng Address <i>(Str</i> ee) Eberle	Drive	ral Route Numb Baltim			Zip Code) 21215 and
	1 and Healt tem 2		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	1	Date		cation - City or	
altimore,	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ Remo 1 □ Donation 5 □ Other (Specify)	val from State Ki	ng"Me	MOTITI		/05	Wood	dlawn.	maryland
alti	permit. Departm Departm Importe any inju		21. Signature of Funeral Service Licensee				ess of Facility Ch	atman-	Har	ris Fu	neral Home
8	90E 9		Jerany Har	ris						timore	, Md 21215 Approximate
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	Physician /Medical		disease or condition resulting in death)	Coro Na	uence of):	triery	Disees	, 4			2 years
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medicel Exeminer:	n: To the best of my kno On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) , date and	and manner as I place, and due	s stated. e to the cause(s)
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2			30. Name and address of person who completed the Mounty of Dan	eted cause of death (Item	23a) (Type.	Print) Siviai	Vospito	l of	Ba	ltimo	2005 Re
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 0 200	32. Legistrar's Signa	15 A						

			1 - For State Registrar	State of Ma	aryland /		artment of H rtificate of L			en@ () () 5 g. No.	15747
N _e	Physici	an	Decedent's Name (First, Middle, I	Last)	1.7	CIND	EDOED		2. Date of Death Month	6 2005	3. Time of Death
	/Medic Examin		SYLVIA 4a. Fecility Name (If not institution, g	rive street and number)	W	FIND	ERGER 4b. City, Town, or	Location of Death	MAT	4c. County of Death	5:00 P M
4			FUTURE CARE						ERSTOWN		TIMORE
of the same	Funeral Director		5. Social Security Number 216-28-8456	Sex 7. Ag	e (In yrs. last l	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 03/09/19	9. Birth Cou	place (State or Foreign intry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD BALTIM	ORE	BALT	IMOR	E				1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			g. Citizen of What Cou	intry?
	eath v	erai	5 POMONA NORTH	#4 12. Was Decedent	Ever in II S	13.1	21208 Was Decedent of His	snanic Origin? (Sna		J.S.A. 14. Race - Ameri	can Indian
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examples rount be recilled.	ğ	1 Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	Armed Forces?			f Yes, specify Cubar	Specify:	Rican, etc.)	Black, White WHI	
2-0	natur	eted	15. Decedent's (Specify only highest of	Education grade completed)	16	(Give	dent's Usual Occupa kind of work done d	uring most of worki	ng 16	6b. Kind of Business/Ir	ndustry
21215-0036	l withir lene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5		OMEM	DONOT use retired) AKFR			OWN HOME	-
Da.	be filed ntal Hygi od other event,	BeC	17. Father's Name (First, Middle, La	st)		<u> </u>		18. Mother's Name	(First, Middle, Ma		•
Maryland	should to nd Ment marked imatic	2	MORRIS			ISHE		LILLIAN		KARP	
N N	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship SEYMOUR WEINBE	* **			ng Address <i>(Street a</i> MONA NORT			City or Town, State, Zij ID 21208	D Code)
altimore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3		20b. Place	of Dispo	sition (Name of natory or other place			c. Location - City or T	own, State
Ē	Pages tment of l tant: If Its jury or o		*4 □Donation 5 □ Other (Spe	city)	AHAVA		ALOM CONG			OSEDALE, N	
Bal	permit. Pages Department of Important: If It any injury or o		21. Significant of Juneral Service Lice	Druge	r	8	900 REIST	ERSTOWN I	ROAD - PI	N & BROS., KESVILLE,	
1			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused by one cause on each li	the death. Dene.	o not ent	er the mode of dying	, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	- a -	a consequence	C off):	entery	Direce			
	Examiner		One and the fire confirm	10 10 10 13	1 Ber	Δ (1):	relitor.	TT			
	Po tis	iner	Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying	Due to (or se	a consequenc	_ '	1				
	xecute and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Cere Due to (or as	a consequence		ular d	useusi			
8760,	ficate be executed physician and s the burial-transit	dicai E		a Ale	heine	urs	Dome	infig			
ဖ	ertifica ling ph		IF FEMALE:	00- 4							
O. Box	that the death certificated by the attending (Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ď.	5 5 6	by Ph	Part II. Other significant conditions	s contributing to death b	ut not resulting	in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ord	w require be en sig should b								1 🗆 Yes	2 No 3 □ Prol	bably 4 DUnknown
Vital Hecords,	The ate h page	Completed							24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of 2 No
Vita	Physician: The Ithis certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othe		(Check only one)		
	£ = E	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b	. Time of	28c. Injury	at A Nursing Hor	me 5 ☐ Resident 28d. Describe how	ce 6 Other (Special injury occurred	(v)
SION	ending sath. or: Aft he fun	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigat		y rear)	Injury	Work M 1 □ Y	es 2 □ No			
DIVISION OF	tal or Attend s after death al Director: / ed in by the f	Certification:	3 Suicide 6 Could not determine		ury - Al home, c. (Specify)	farm, str	eel, factory, office	1	28f. Location (Stre City or Town, :	et and Number or Rur State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination a	ge, death and/or inv	occurred at the tim vestigation, in my op	e, date and place, a inion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Len	w		29c. License	number 7075-	290	Date signed (Month,	Day, Year)
	1,7		CLAUDIO LEUI	· · · · · · · · · · · · · · · · · · ·	750	(Type,		Reisten	tour a	10 211	36
廖	Sta Registr		31. Date filed (Month, Day, Year) MAY 1	2005 32. Registr	ar's Signature	K A	bede				

			1 - For State Registrar	State of Marylan	d / Depa		lealth and I	Mental Hyg	-	15	15748
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Las Robert	Т		Williams	r Location of Death	2. Date of Deat Month May 7	Day 4c. County	2005	3. Time of Death 9:15 AMM
	Funeral	er	4a. Facility Name (If not institution, give Genesis Health 5. Social Security Number 220-24-2784	Care Spa Cree	last birthday)		napolis	8. Date of Birth (Month, Day, JAN 29	Anr	ne Aru	ace (State or Foreign
	Director	irector	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	1 S			0g. Citizen of	11	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II a Madical Examinat must be multified at	Completed by Funeral Director	35 Milkshake La 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes ② No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Bla	ce - Americ ck, White, e ý: Whit	etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other then "netur: ant, Ire Piscilcall		15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire UCK Drive	during most of word)	king		Trac	tor Traile
Maryland	12 should be filed within and Mental Hygiene. 7 Is marked othar than Iraumatic avant, Ire M	To Be	Robert L. 19a. Informant's Name/Relationship (7 Kathi Drenning (Betsy and Number or Ru Hollow R	Hil (debranc ; City or Town	t, State, Zip	
Baltimore, I	9 ± 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Me	Place of Disponentery, cre tro Cr	osition (Name of matory or other pla ematory	nc. May	Date 9 2005 1	20c. Location Baltimo	-city or To ore MD	wn, State
Bali	permit. Pa Departmen Important any injury		21. Signature of Funeral Service Lico 23a. Part 1. Enter the sisease, or com- shock, or heart failure. List only	3			ntain Roa		na MD 2		Approximate Interval Between Onset and Death
790, /	eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, saturing to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d.	uence of):	nami	Λu'				1uh
.O. Box 68	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	death 3	⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i>) _	у		1	ate of delive	ry Day Year
of Vital Records, P	To the Hospital or Attending Physicien: The law requires that within 24 hours after death. To the Funaral Diractor: After this certificate has been signed be completely filled in by the funeral director, page 2 should be detained.	by	- Part II. Other argument contained continuously to doubt for receiving in the disconying dates given in rate.						b. Did tobacco use contribute to the cause of death? 1 Yes 2 Dob 3 Probably 4 Unknown 1. Was an 24b. Were autopsy findings available		
		e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was a autops perform 1 Yes	sy med? 2⊊2No	prior to con death?	npletion of cause of
		ation: To B	examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju		lome 5 Reside 28d. Describe ho	ow injury occu	rred	
Division		I Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hos within 24 ho To the Fun completely the	Medical		niner: On the basis of examina and manner stated.		envestigation, in my	opinion, death occu	erred at the time, d	ate and place	and due to	the cause(s) Day, Year)
_	Y		Gay J. Spra	completed cause of death (Itel	DIDA	Print) Or 1	3236 ue Chr	Le, MJ	21619		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 0 2005	32. Registrar's Sign	ature	E)					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month **Physician** April 21, 11:23 AM Franklin Daniel Andrews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 20,1926 | Baltimore, MD 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 11XM 2□F Yrs. Director 78 212-22-8864 Usual Residence of Deceden with the Maryland 10b. County 10c, City, Town or Location 10a State 10d. Inside City Limits 28a-f shov ust be notified at 1 X Yes 2 No Director MD Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 11514 Patapsco Drive 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 2 1 1 No WWII If Yes, Give Year or Dates: Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. onents it stem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner of a. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: Specify þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank C. Andrews Catherine M. Getz permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11514 Patapsco Drive, N. Bethesda, MD Cleo Andrews, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. April 26,2005 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the likease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.

Immediate Carise (Final disease or condition resulting in death)

a. Cong ESTVE CARDIOMYOPATHY Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 ian/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has M No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 EN/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/22/05 10-27660 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE PILLE ROCKVILLE MD 20852 ALPANA GOSWAN M.D. 11119 31. Date filed (Month, Day, Year) 3. Registrar's Signature State APR 2 6 2005 Registrar

30/12/1/0

trateus, Franklin

Physician / Decedent's Name (First, Middle, Last) REBECCA ABRAMOWITZ 4a. Facility Name (If not institution, give street and number) 6111 MONTROSE ROAD, APT. 216 Social Security Number 6111 MONTROSE ROAD, A				1 - For Stete Registrar	State of M	aryland		artment of H <i>tificate of L</i>	ealth and M Death		giene 0 0 5	15750	
EXEMPTION SERVICES EXAMPTION TO THE CONTROL OF A A A PORT VILLE OF THE CONTROL O										2. Date of Dea	th	3. Time of Death	
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Social Section Number Soci		Examin	er			_							
Second Content of Co		Eupoval	4				ast birthday)	If Under 1 Year		8. Date of Birth			
Uncompared and processes Uncompared and proc				050-09-1555	M 2 ∑ F	9	94 Yrs.	Months Days	Hours Min.	(Month, Day, 06/06/1		ountry)	
Specific Performance Specific Performance		pug *				10c. City	Town or Lo	cation					
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Specific Performance Specific Performance		23a c	aD	6111 MONTROSE ROAD,	APT. 21	6		20852			U.S.A.		
Specific Performance Specific Performance		er dez items	nue	11. Marital Status	2. Was Decedent Amed Forces?	Ever in U.S	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)			
Specific Performance Specific Performance	35	urs aft			If Yes, Give	NO		I□Yes 2X No	Specify:		Specify:	WHITE	
The Control case retrieved by the Co	ב ב	72 na	sted	15. Decedent's Education 16a. Decedent's Usual Occupation				ution	ug.	16b. Kind of Business). Kind of Business/Industry		
17 First Name Perd, Morde, Last	Z	within ne.	mpie	Elementary/Secondary (0-12))	,9			
Isaac Hanthan	Z	lled lyg he	ပ္ပ				HOUSE	/IFE	18. Mother's Name	(First. Middle. I			
Physician Medical Examiner Region of the state of the st	an	0 = 0 %			HANTMA	N							
Physician Medical Examiner Region of the state of the st	ary	shou and N s mar					19b. Mailin	g Address (Street a				Zip Code)	
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Physician Medical Examiner Region of the state of the st	or e	it of H		1 X Burial 2 ☐ Cremation 3 XR	emoval from State	ce	metery, cren	natory or other place	9)	7	20c. Location - City or	Town, State	
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Physician Middlan Middlan Examiner Physician Middlan Middlan Examiner Physician Middlan Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Middlan Examiner Physician Physi	n	Department Department		1 (Imanda-	Kud OII	ra	110	9 L ROCK V I	плж рікк.	ROCKVI	T.T.F. MD 20	1852	
Physician // Modellar Examiner Page	Г		П	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on each li	the death	. Do not ente	er the mode of dying	, such as cardiac or	respiratory arre	est,	Approximate	
Due to (or as a consequence of): Securitary Securita				Immediate Cause (Final disease or condition ATHEROSCLEROTIC HEART DISEASE YEARS								Onset and Death	
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The past 12 months? Company Com	L	d y	ler	if any, leading to immediate									
The past 12 months? Company Com		cuted nd ransit	amir	that initiated events									
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 10 yes 2 long and the	Ď,	ое өхө cian aı ourial-1		resulting in death) Last	Due to (or as	a consequ	ence of):						
So of the state of	200	icate t	dica	0									
9 Unknown 9 Unkn	Ξ.				Bc. If yes, outcome	of pregnar		le			23d. Date of de	livery	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death?		death	sicia	1 ☐ Yes 2 ☐ No	4☐Pregnant at						Month	Day Year	
24a. Whas an autopsy performed? 1	٦.	d by the	٥			ut not recui	ting is the up	idarhina agusa gira	n in Dard I	220 Did tob	anne una contributa t	the course of death?	
24a. Whas an autopsy performed? 1	ds,	signe				at not room	ang in the un	denying cause give	mmr arti.				
Second Page	CO	S D S								24a. Was ar	24b. Were au	utopsy findings available	
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1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and didle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 35c. Pending investigation 1 Month, Day Year		di Si	-	M res 2 No	1 L Inpatie	-		3 DOA	4 Nursing Hom			cify)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY A. PERLMUTTER, M.D., 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND, 20852		ing Ifter	tion	1 XNatural 5 □ Pending (Month, Day Year) Injury Work?						d. Describe how injury occurred			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY A. PERLMUTTER, M.D., 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND, 20852		Attan r deat actor: by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office						3f. Location (Str	Location (Street and Number or Rural Route Number,		
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY A. PERLMUTTER, M.D., 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND, 20852		o tha ithin 2 o tha			and manner sta	ited.	Δ	29c. License	number	29	d. Date signed (Mont	h, Day, Year)	
36 Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY A. PERLMUTTER, M.D., 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852		->-0		effor G to ll Im DA7188						PRT1 22 2	2005		
JEFFREY A. PERLMUTTER, M.D., 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852 State Registrar APR 2 6 2005		3						Print)					
Registrar APR 2 6 2005 Community By April 19 19 19 19 19 19 19 19 19 19 19 19 19				JEFFREY A. PERLMUTT	ER, M.D.	6240	MONT	ROSE ROAD	, ROCKVIL	LE, MAR	YLAND 2085	2	
					Gladue	, K	GORA	See !					

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WILLIAM A. BALL, JR. 23, 8:30 PM APRIL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1√2 M 2 □ F 579-20-3703 84 Yrs. VIRGÍNIA Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "naturat", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No ARLINGTON NONE Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2448 S. NELSON STREET 22206 USA filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates 1943——4 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER U. S. POSTAL SERVICE 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event 9008. Be WILLIAM A. BALL. SR. SYLVIA COLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11th ST. NW WASHINGTON, DC (#235) LAUREN REYNOLDS (DAUGHTER) 2004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) QUANTICO NATIONAL 05/02/05 TRIANGLE. VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PEYTON FUNERAL HOME olurson 2205 S. SHIRLINGTON RD. ARLINGTON, VA 22206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician SEPSIS** DAYS /Medical Due to (or as a consequence of) Examiner DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27 Manner of Death After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D - 32332APRIL 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 GEORGIA AVE. #220 SILVER SPRING, MD 20902 S. K. GUPTA 31. Date filed (Month, Day, Year, State APR 2 7 2005

DHMH 17 Rev 1/2001

Registrar

				Department of Health and Mo Certificate of Death	ental Hygie	6000	15752				
I	Physici	ian	Decedent's Name (First, Middle, Last) P		2. Date of Death	Day Year	3. Time of Death				
	/Medic Examir	cal	BEVERLY SUE BOLTON. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	APRIL 1	4c. County of Dea					
	Exami	IGI	Shady Grove Adventist Hospital	Rockville		Montgome					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bin	th place (State or Foreign puntry)				
H	Director		461-47-4024 30 Usual Residence of Decedent	D	ec.31, 1	974 Tex	as				
	arylan show	2	10a. State 10b. County 10c. City, Town				10d. Inside City Limits				
	the M 28a-f	Director	MD Montgomery Rockvil	10f. Zip Code	100	Citizen of What Co	1 X Yes 2 □ No				
	death with the Maryland ms 23a or 28a-f show r must be notified at		886 College Parkway, Unit T-1	20850		.S.A.	Juliu y :				
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R		14. Race - Ame Black, Whit					
0000	within 72 hours after ene. than "natural", or Ita	by	1 X Never Married 2	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite				
2	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	g 16t	o. Kind of Business					
V	within ene. than he Me	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)		None					
and	e filed al Hygi othar vant, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name							
ylai	2 should be and Mental Is markad sumatic av	To	Wesley Wayne Bolton	Carolyn							
Ma	d 2 sh th and th and ?7 ls m traum			Mailing Address (Street and Number or Rural			Zip Code)				
e,	s 1 an of Heal itam 2		20a. Method of Disposition 20b. Place of	D. Box 1911, Rockvill Disposition (Name of crematory or other place)		Location - City or	Town, State				
Daltimor	Page ment of ant: #		122 Bartar 2 Gordination 6 Gridinavarilloni ciale	l l	/2005 Gen	rmantown,	Maryland				
מ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury octher traumatic avonce.		21. Signalure of Funeral Service Licensee		mple Tril		1 00050				
ı			23a. Part 1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								
1	Firysician :	105 2	Interval Between								
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. CERBRA EDEMA Due to (or as a consequence of): Sequentially list conditions b. STATUS EPILEPTICUS 1/								
		er	Sequentially list conditions, if any, leading to introdiate			11 04.42					
	cuted nd ransit	Examiner	if any, leading to initradiate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
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00/00	ificate be executed g physician and as the burial-transit	edical	d.								
2	leath certifu attending I i for use as		IF FEMALE: 23b. Was decedent pregnant in the prest 13 growths? 1 □ Live birth 2 □ Fetal death		23d. Date of delivery Month D						
5	w requires that the death cer been signed by the attendin should be detached for use	Physician/M	in the past 12 months? 1 Yes 2 X No 9 Unknown Unknown	4☐Pregnant at time of death 5☐ Other (specify)							
Ļ	s that t ned by e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?				
S S	equire en sig ould b	ted b			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown				
ב ב	e law r has be je 2 sk	ompleted			24a. Was an autopsy	prior to d	topsy findings available completion of cause of				
פ	iician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical	OO Pleased Develo	performed		3-10 No				
>	nysicia nis cert direct	To B	examiner? 1 Yes 2 No	26. Place of Death (Datient 3 □ DOA Other: 4 □ Nursing Home		6 □Other (Spec	eify)				
2	I or Attanding Phys after death. Diractor: After this I in by the funeral di		- Interest of the contents	me of 28c. Injury at 28 jury Work?	d. Describe how in						
	Attanc r death actor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury : At home, farm	M 1 Yes 2 No	of. Location (Street	and Number or Ru	ral Route Number.				
5	ital or irs afte ral Dir	Cert	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)					
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)								
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)				
	- A		AJIT P. KURUVIL		Ar	RIL 19,	2005				
	V		30. Name and address of person who completed cause of death (Item 23a) (TAJIT P. KURUVILLA, M.D., (//25	ype, Print) ROCKNILLE DELE HO	of for	VILLE AA	A ratera				
	Sta	te	31. Date filed (Month, Day, Year) APR 2 6 2005 32 Registrar's Signature	PROCKVILLE PRICE #2	TUO TUE R	, pri	0 70877				
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			A COLUMN TO THE	Department of Health and Mental Certificate of Death	Hygiene 0 0 5	15753
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mary E. Booze	2. Date of Month Apri	of Death	3. Time of Death 11:25 A M
	Examir		4a. Facility Name (If not institution, give street and number) 3109 Plyers Mill Road	4b. City, Town, or Location of Death Kensington	4c. County of De	ath ry
	Funeral Director		5. Social Security Number 119-09-0048 Usual Residence of Decedent 6. Sex 1 M 2 X F 7. Age (In yrs. last birth 19 M 2 X F	Months Days Hours Min. (Month		irthplace (State or Foreign Country) York
	the Marylan 28e-f show	ector	10a. State 10b. County 10c. City, Town MD Montgomery Kensing 10c. Street and Number		100 0111-1-1011-10	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	sath with	Funeral Director	3109 Plyers Mill Road	20895	10g. Citizen of What C	
9800	ours after de rel', or item Evantive	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. □ Yes 2 No Specify:	or No- .) 14. Race - Am Black, Wh Specify: W	ite, etc.
)-61212	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or items 23a or 28e-f show event, the Medical Evan from the nuffiled at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hot	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) memaker	16b. Kind of Business	s/Industry
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other then "neturel", or items 23a or 28e-f show umatic event, I'm Medical Everal art mast te truffical at	To Be C	Joseph Russo	18. Mother's Name (First, Mid Teresa Filard	0	
	1 and 2 dealth a sm 27 is ther tree		George Booze, Husband 310	Mailing Address (Street and Number or Rural Route No. 09 Plyers Mill Road, Kens: Disposition (Name of prematory or other place)		Land 20895
Baltimore,	permit. Pages Department of I Importent: If its eny injury or or			ncoln Crematory 04/25/2005 22. Name and Address of Facility Simple T	Brentwood,	
n	89 E 8 8		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	1040 Rockville Pike, Roc	kville, Mary	1and 20852 Approximate Interval Between
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O. Box 6	the death certification of the attending properties and the action of th	hysician/Medl	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	olivery Day Year
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r	The law ate has b page 2 sl	Completed		a p	Vas an 24b. Were a prior to death? ss 2 ♥ No 1 □ Yes	utopsy findings available completion of cause of s 2 No
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	the Hosp nin 24 hou the Fune	fedical	29a. Certifier (Check only one) 1 M Certifying Physician: To the best of my knowledge, (Check only one) 1 Medical Examiner: On the basis of examination and manner stated.	or investigation, in my opinion, death occurred at the tin	the cause(s) and manner as ne, date and place, and due	s stated. e to the cause(s)
		Σ	29b. Signature and alle of certifier Supplied to the state of the sta	29c. License number D57630	April 22, 2	
	3		30. Name and address of person who completed cause of death (Item 23a) (T Anuradha Arun, MD, 10301 Georgia Av	ype, Print)		
H	Sta Registra		31. Date filed (Month, Day, Year) 32. legistrar's Signature APR 2 6 2005			

		-	For State Registrar	State	of Marylan		artment rtificate				-	giene Reg. No.	. U U :	5	15754
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath Day	Ye	ar	3. Time of Death
	Physicia /Medic		DONALD RIC	HARD BUT	LER						APRIL		2005		5:00 P M
	Examin		4a. Facility Name (If not institution	, give street and no	ımber)		4b. City, To	own, or	Location of	of Death		4c.	County of E	Death	
			GARRETT COUNTY				If Under 1		LAND If Under	24 1140			GARRE'		(2)
	Funeral Director		5. Social Security Number 311–32–2805	6. Sex 1 X M 2 □ F	7. Age (In yrs. 69	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da AUG 10,	y, Year) 193	5	Countr	Ice (State or Foreign DIANA
	land	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
	Mary -1 eh	to	MD GAR	RETT		OAKLAN	D								1 ☐ Yes 2X No
	r 28a	irec	10e. Street and Number				10f. Zip 0	Code				10g. Citi	zen of Wha	t Countr	y?
	h with	Funeral Director	84 BIRCH LAN	E				215.	50				USA	A	
	eme	ner	11. Marital Status	Armed F	cedent Ever in U.	.S. 13.	Was Decede	nt of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - A Black, V		
ဝ	or It		1 Never Married 2 Mar	ied 1 X Yes If Yes, G	2□N⊕/9/ ive Dates8/26/	55-1	1□Yes 2		Specify:				Specify:		
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		BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
Maryland	s 1 and 2 should ba filed f Health and Mental Hygi tem 27 le marked other other treumatic event, I	ToE	PAUL 19a. Informant's Name/Relations	BUTLER		10h Maili	a Address /	Street 2		MABEL	I Route Numbe		HKEN	te Zin (Code
<u>a</u>	d2: thar thar treu		CAROL BUTLER -			1					ND, MD		550	10, <i>Lip</i> (,000
	Heal Heal tem 2	1	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of	1		ate		cation - City	y or Tow	n, State
altimore,	0 0 = =		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State	emetery, crei RETT M	-			5 /	5/05	,	ገለፑፐ ለክ	JD.	MARYLAND
≣	permit. Pag Depertment Important: I any injury c	1	21. Signal of Fun cal project		GAR.	Committee of the commit	2. Name and		_				x 243	ч D,	MAKILAND
ä	Dep Jany		John My	unet 1	100167	D	URST I	TUNE	RAL I	HOME	- OAKL			2155	0
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	onty one cause on	caused the deat each line.			of dying	g, such as	cardiac o	r respiratory ar	rrest,			Approximate Interval Between Onset and Death
0	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):									
	LAMITIME		Sequentially list conditions,	b. MRS	SA o (or as a conseq	wanna of								-	3 MONTHS
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indentying Cause (Disease or injury		EUDOMONA									2	MONTHS
	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	C.	o (or as a conseq										MONINS
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O	fing After fune	tion	1 XNatural 5 ☐ Pendir		of Injury nth, Day Year)	Injury	м	c. Injury Work	(?` ∕es 2 🔲				,		
Division of Vital	I or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could	not be 28e. Plac	ce of Injury - At h	ome, farm, st	reet, factory,	office		2				r Rural	Route Number,
2	i Si te	Certification:	4 Homicide	buil	ding, etc. (Specif	'y)					City or Tov	vn, State)		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely tilled in by the	edical C		ng Physicien: To the Exeminer: On the and ma											
	of thin forthin compli	Me	29b. Signature atro title of certifie			/	29c.	License	number				e signed (N		
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6	AVA		30. Name and address of person												
L	, .		KEN R. BUCZYN 31. Date filed (Month, Day, Year,		., 311 N Registrar's Signa		STREET	r, s	UITE	1, 0	AKLAND	, MD	2155	50	
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		_	For State Registrar	State of Mar	-	artment of F		lental Hygier Reg.	2000	15755
	Physicia /Medic		1. Decedent's Name (First, Midd FILA NC83		BRA	4			Z5 O	3. Time of Death
	Examin	er	0,1,1,0	unt men	novial	Oa	r Location of Death Klanc	2	4c. County of Dea	elt
	Funeral Director		5. Social Security Number 20 28 7500 Usual Residence of Decedent	6. Sex 7 7. Age 1 M 27 F 86	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Mar 6, 1	ar) Co	thplace (State or Foreign Suntry)
	Maryland	tor	10a. State 10b. Count	rett	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28e	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	eath w	eral	189 Pleasant	HILLS CITCLE 12. Was Decedent Ev	ver in IIS 13	21550	lispanic Origin? (Spe	acify Vas or No-	USA 14. Race - Ame	arican Indian
5-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	Armed Forces? 1 ☐ Yes 2 ☒ No		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	Rican, etc.)	Black, Whit	e, etc.
21215-0	ithin 72 ho ne. han "natu e Wedical	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed) College (1-4or 5+)	(Give		pation during most of working d)	ng	. Kind of Business	/Industry
2	filed w Hygier sthar tl	CO	17. Father's Name (First, Middle	, Last)	Ho	usewife	18. Mother's Name	HOT (First, Middle, Maid	nemaking	
aŭ	should be and Mental smarked o	To Be	Thomas Coste				Beulah Rh		,	
Maryland	2 shou and M is mar aumat		19a. Informant's Name/Relation		19b. Mail	ing Address (Street		I Route Number, Cit	ty or Town, State, .	Zip Code)
	1 end 2 Health am 27 othar tra		William Bray		189 20b. Place of Disp		Hill Circ		and, MD	21550
0	Pages hent of H			3 ☐Removal from State	cemetery, cre	matory or other plac	ce)	Cu	Location - City or mberland	
altimore,	permit. Page Department of Important: if eny injury or once.	- 1	*4 ☐ Donation 5 ☐ Other (, 2	2. Name and Addre		122	doels Du	
<u>~</u>	Depar Impo	F 1	- Clory	A Burdoo	R 71	0 Church	St. Kitzm	rid A. Bur uiller, MD	21538	
	Physician /Medical Examiner	Iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a	consequence of):	ts pert	ens TM	CHF		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	ivery Day Year
rds, P.	w requires that to be been signed by should be detailed	by	Part II. Other significant condi	tions contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	,	o the cause of death?
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Vita	sician certific rector	Be	25. Was case referred to medic examiner?	Hospital: 1 Unpatient		oth acidos Oth	26. Place of Death		- 50	
Division of	ing Phy n. After this funeral c	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pence inves	28a. Date of Injury	28b. Time	of 28c. Injur	y at	me 5 Residence 28d. Describe how in		ciry)
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	To the Hospital within 24 hours e To tha Funaral I completely filled	edical	(Check only 2 Medica one)	ing Physician: To the best of al Examiner: On the basis of e and manner state	examination and/or in	nvestigation, in my c	pinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
)	To with To Con	×	29b. Signature and title of certif	Dullip	80	29c. Licens	26154	29d.	Date signed (Mont	1. Day, Vear) 21550
			30. Name and address of person		ath (Item 23a) (Type 9Wo K	- Acres	dr. O	akland	e, me	21550
	Sta Registi	. 6	31. Date filed (Month Day, Yea	32. Redistrar	s Signature	Gradh 1				

		Í	For Stata Registrar	State of	Maryland / [Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	ind M		iene	5	15756
	Obveisi		1. Decedent's Name (First, Middle,	Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Jack E. Bonne	Y							April	24 200		9:00 p ^M
	Examin	er	4a. Facility Name (If not institution,		er)		4b. City, 7	Town, or	Location o	f Death	-	4c. County	of Death	
			829 Snowfall Wa						nste			Ca	arro.	
	Funeral Director			.Sex 7. 1,527 M 2 □ F	Age (In yrs. last bir.	thday) Yrs.	If Under Months	Days	If Under :	Min.	8. Date of Birth (Month, Day,		9. Birth Cou	place (State or Foreign intry)
			064-05-3703 Usual Residence of Decedent		93						August	8 1911		MD
	yland		10a. State 10b. County		10c. City, Town	n or La	cation							10d. Inside City Limits
	a-fsl	iot	MD Carr	roll	West	mir	ster							1 ☐Yes 2 XNo
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code			11	Og. Citizen of W	/hat Cou	intry?
	238	rai	829 Snowfall Way	<i>-</i>				2115	7			USA		
	ar deg	nue	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Decede f Yes, speci	ent of His fy Cubar	spanic Orig	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		- Ameri k, White	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1□Yes 2	√2 No	Specify:				Wh:	
응	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show than Jical Exercit or mant be notified at		15. Decedent's			Dece	ient's Usual	Occupa	tion			16b. Kind of Bu		
15	n "na	piet	(Specify only highest	grade completed)		(Give	kind of worl DO NOT use	k done di e retired)	urina most	of worki	ing	TOD. KING OF DU	3111033211	loustry
212	d with giene ir tha	Completed	Elementary/Secondary (0-12) 12	College (1-4	01 5+)		Sales	man				Ret	ail	
g	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or liams 23s or 28s-f show event, the Medical Exercitor nast be nulliked at	Be (17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle, A	Maiden Sumam	э)	
yla	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic event, the M.	은	(unknown) Bo					Į			Stewart			
Mar	ges 1 and 2 should it of Health and Mer if Itam 27 is marke or other traumatic	- 0	19a. Informant's Name/Relationship								d Route Number,			
<u>ر</u>	l and fealth im 27 her t		Margaret Bonney	wire			Snow			-	stminste		2115	
Baltimore, Maryland 21215-0036	tif its		20a. Method of Disposition 1 ☐ Cremation 3						1		4	20c. Location -		
薑	it. Partmer rtant njury		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lin		Lake						7/2005	Sykesv	rille	e, MD
Ba	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other tra once.		21. Signature of Funeral Stroke En	1000		22	. Name and Pritt	s Fu	neral	Hor	me and C	hapel,	P.A.	21157
			23a. Part1. Enter the disease, or co	mplications that cau	sed the death. Do r	not ent	412 W	ashi	ngtor	Rocardiac o	ad West	minster	, MI	Approximate
	Dhusisian		snock, or neart failure. List or Immediate Cause (Final	ly one cause on eac	h line.	1		9	Λ		intro			Interval Between Onset and Death
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	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.										
8760,	icate be executed physician and s the burial-transit	Ě	resulting in death) Last	Due to (or	as a consequence	of):								
87	physi the t	dicai		d.			_						-	
9 X	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy							204 D.W	-4-4-1	
Вох	atter I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birtl	n 2 ☐ Fetal death t at time of death		Ectopic pre Other (spe					23d. Date Mon		Day Year
P.O.	that the di ed by the detached	nysi	1 Yes 2 No 9 Unknown	9□ Unknow										
	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Me	Part II. Other significant condition	contributing to deat	h but not resulting in	the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use contri	bute to t	he cause of death?
Records,	v require been sig should b	ed t	ADENCALCIN	om a cf	co10~						1 □ Ye	s 2 No	3 🗌 Prot	oably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
	ys d	^o L	1 ☐ Yes 27 No	Hospital: 1 Inp		tpatien			7 110		ne 5 Reside			(y)
Ē	ing P	ion;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	njury 28b. T Day Year) Ir	ime of njury		c. Injury Work			28d. Describe ho	w injury occurre	d	
Sign	Attanding r death. actor: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could no	be Goo Diese of	Jaium, Athana fa		M		es 2 🗆 N		304 Lanatina (Cta			
Division of	after Dirac	Certification;	4 Homicide determin	building	Injury - At home, fa , etc. (Specify)	rm, str	eet, ractory,	OTTICE		1	28f. Location (Str City or Town,	State)	or Hurs	ar Houte Number,
	spita nours naral		29a. Certifier 1 Certifying	Physician: To the be	est of my knowledge	, death	occurred a	t the time	e. date and	place, a	and due to the ca	use(s) and mar	ner as s	tated.
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex	aminer: On the basi and manner	s of examination an	d/or inv	estigation,	n my opi	nion, deat	h occurre	ed at the time, da	te and place, a	nd due to	the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				1700	License				d. Date signed		
)	-			مسم			1	7:31	66	C		26/140	120	10°E
	WIL		30. Name and address of person wh		of death (Item 23a) (Type,	Print)	er	Aven	rve	vies7	Men ST	th	2.1157 MARY LAW
	Sta Registr		31. Date filed (Month, Day, Year) APR 2	2005 32. Reg	Strar's Signature									<u> </u>

State of Maryland / Department of Health and Mental Hygien 0 0 5 1- State Registrar Amended # 4a per FH; FCHD Certificate of DeathTM 4/27/05 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ALLEN COON RICHARD 740 PM APRIL 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) adventist 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Sdventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 216-60-3598 52 1952 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-t show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick New Market Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10708 S. Glade Court 21774 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Building Engineer Real Estate 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ia marked oth any linjury or other traumatic even <u>once.</u> Be 18. Mother's Name (First, Middle, Maiden Sumame) Percival George Coon Dorothy Elizabeth Hegarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie M. Coon / Wife 10708 S. Glade Court New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Frederick, Maryland 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADENOCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trai Due to (or as a consequence of): トばひ みんし Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident the within 24 hours after deat To the Funeral Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signatura and title of our 29c. License number 29d. Date signed (Month, Day, Year) APRIL 27, 2005 00061083 30. Name and address aperson who completed cause of death (Item 23a) (Type, Print) Thambi, M.D. 9707 Medical Center Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) APR 2 istrar's Signature 32. Ru State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 24a per Verb., G843 05/10/05dhb ath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year GRACE D. CLARKE April 30, 2005 4:00A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3042 Tipton Way Abingdon Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🛣 📉 56 Director 217-50-6322 5/26/1948 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28e-1 show 10d. Inside City Limits the Medical Examiner must be notified at Director Harford Abingdon 1 X ★es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 3042 Tipton Way 21009 USA Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1. Yes 2. No If Yes, Give Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 XX o Specify: \$ Specifywhite 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within 7 of Health and Mental Hygiene. Item 27 is marked other than "r other treumatic event, the Med College (1-4or 5+) 2 years Elementary/Secondary (0-12) Teller Banking 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Davis Bentley Della Mae Mullins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other treu once. Leonard R.Clarke/Husband 3042 Tipton Way, Abingdon, MD 21009 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Salem Cemetery 5/4/2005 `4 Donation 5 Other (Specify) Delta, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Linestin (Pidi, discuse) Frontal temporal **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Iclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached o Physi 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1□ Yes 2X No Division of Vital 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ≥ No 2 After thi funeral 27. Manner of Death Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel L 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29277 , vhp May 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Patricia Dubyoski, W. McPhail Road, Bel Air, MD 31. Date filed (Month, Day, Year) MAY 1 0 2005 32. Registrar's Signature State Registrar

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			1 - For State Registrar	Ctate of Wi	ai yiai		rtificate of			g. N2. () () 5	15750
			Decedent's Name (First, Middle, I	Last)					2. Date of Death	1	3. Time of Death
	Physici /Medic		Kathryn Ann	n Caell					April 2	24 ^{Day} 200 ^{Year}	10:04 AM
	Examin	R	4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town, o	or Location of Death		4c. County of Dea	th
			Wilson Health		r			rsburg		Montgo	
	Funeral		5. Social Security Number 6. 469–18–6322	Sex 7. Ag		last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign ountry)
ŀ	Director		Usual Residence of Decedent		86	113.			April 23	3, 1919 Mi	nnesota
	yland yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	B Mar	ctor	Maryland Montgo	omery	(Gaithe	rsburg				1 X Yes 2 ☐ No
	ith th or 28	Director	10e. Street and Number				10f. Zip Code			g. Citizen of What Co	•
	s 23a	ral	301 Russell Av			0 1.0	208			United Sta	
_	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣		.5.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
99	urs at	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2Ã No	Specify:		Specify: W	hite
Maryland 21215-0036	iiled within 72 hours atter death with the Maryland Hygiene. ither than "naturel", or liems 23a or 28a-f show ith, the Medical Evaninar must be notified at	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup	pation	cina 1	6b. Kind of Business	/Industry
2	han "	mple	Elementary/Secondary (0-12)	College (1-4or :	5+)			during most of work d)			
22	Hygie Hygie Iher ti nt, Ib		17. Father's Name (First, Middle, La	4		Teach	er	19. Mother's Nam	e (First, Middle, M	Education	
and	m - 0 5	o Be	Alex Satka	31)					se Berna:		
<u></u>	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. is marked other than "naturet", or items 23a or 28a-f show sumatic event, the Medical Examinar must be notified at	٦ ر	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)
	and 2 ealth a n 27 is		Raymond K. Cae	11 / Son			Bayard 1			Maryland 2	
Baltimore,	- T 6 =		20a. Method of Disposition 1 Burial 2 Cremation 3	Dameuri from State	20b. F	Place of Dispo	sition (Name of matory or other place	ce) April	Date 2	Oc. Location - City or	Town, State
Ē	Pages ment of lent: If he ury or g		'4 □ Donation 5 □ Other (Spec		1	odlawn	Cemetery	2005		Winona, M	innesota
3alt	permit. Pages Department of I Importent: If Ite any injury or or		21. Signature of Funeral Service Lic	(500)			. Name and Addre			ral Home	
	00 = e o	- 12	Curlis 2 .	Sul,	4.45. 44			Park Dr.		rsburg, M	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ne.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Pneumon							24 Hours
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):					
	te be executed ysician and e burial-transit	Examiner	that initiated events	C							
760,	oe exe	i Ex	resulting in death) Last	Due to (or as	a conseq	uence of):					
6876		dicai		d							
9 X	death certitica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incy				23d. Date of del	livany
Вох	atten d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₭ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	/		Month Month	Day Year
0	at the de by the a tached	hysi	9 Unknown	9□ Unknown							
o, o	ss this gned se de	by P	Part II. Dther significant conditions				, ,			acco use contribute to	
ord	w require been si should t		Recent Parieta					<u>;</u>	1 🗆 Yes	s 2□No 3□Pr	obably 4X Unknown
ပို	law r las be	Completed	Crohn's Diseas	e; Urinary	Trac	t Infe	ction;		24a. Was an autopsy	prior to	topsy findings available completion of cause of
E E		Con	Anemia of Chro	nic Disease	; Hy	pothyr	oidism; I	Dysphagia	perform 1 ☐ Yes 2	ed? death? ∑No 1 ☐ Yes	2 🗆 No
	sicien certiti rector	o Be	25. Was case referred to medical examiner?	Hospital:			Oth		h (Check only one		
Division of Vital Records,	this ald	-	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inju	ry	ER/Outpatien 28b. Time of	28c. Injur	y at	ome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spec	cify)
0	nding Fath. r: After e tuner	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)	Injury	M 1 🗆	k? Yes 2 □No			
VIS	r Atte er dez recto	Certification;	3 ☐ Suicide 6 ☐ Could not determine		ury - At ho	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	itel or rs afte rel Dir lled in										
	ne Hospitel or Attendi n 24 hours after death. Ne Funerel Director: A pletely filled in by the tu	edical	29a. Certifier 1 ☐ Certifying I (Check only one) 2 ☐ Medical Ex	Physician: To the best aminer: On the basis o	f examına	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	and manner st	ated.		29c. Licens	e number	29	d. Date signed (Monti	h, Day, Year)
			1 / ARrun	th	11	1 / 26	/	4115	,	,	
1	0		30. Name and address of person wh		leath (Item	1 23a) Type.	20			poux	1,2005
			H. Robert Birs	schbach, M.	D. 2	201 Rus	ssell Ave	nue Gait	hersburg	, Maryland	1 20877
	Sta		31. Date filed (Month, Day, Year) APR 2 6	32 Tegistr	ar's Signa	H Lo	will				
	Registr	वा	MINUU	LOUS MICH							

			State of Maryland / De 1- State Registra MEND#IperMD4/26/05, PMW, McCo C	partment of Health and l ertificate of Death		iene g. No.	15760
	Dhuaiai		Decedent's Name (First, Middle, Last) ROBERT TF	OMAS COLIHAN	2. Date of Deat	th	3. Time of Death
ı	Physicia /Medic				APRIL	19, 2005	7:55 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Deat	h
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Silver Spring v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		omery
ı	Funeral Director		169-18-4470 X□M 2□F 83 Yrs.	Months Days Hours Min.			hplace (State or Foreign nuntry) nnsylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary I-1 sh	tor	Maryland Montgomery Roc	kville			1 ☐ Yes 2 🙀 No
	th the or 284	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-1 show rmast be rediffed at		4914 Arbutus Avenue	20853		USA	
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "neturel", or Items 23e or 28e-1 show event, the Medicel Evaluar of mast be positived at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert □ Yes 2 No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: White	e, etc.
2 C	72 ho natur	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	king	16b. Kind of Business/	Industry
7	within 72 ene. than "nai	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
N.	filed Hygie other		17. Father's Name (First, Middle, Last)	deral Investigator 18. Mother's Nar	ne (First, Middle, M	Federal Go Maiden Sumame)	vernment
Maryiand	should be nd Mental markad c matic eve	To Be	Thomas Colihan		n Wedro	,	
a	2 should be and Ment Is marked		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	iling Address (Street and Number or Ru	ıral Route Number	, City or Town, State, 2	Zip Code)
	12 a			14 Arbutus Avenue,	Rockvil	le, Maryla	nd 20853
Baitimore,	W		1 □ Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Metropoli	+ C	11 25,	20c. Location - City or Alexandria	
Bail	permit. Page Department of Important: If any injury or once.		21. Signature Faneral Service Ligansee	Francis J. Collins 500 University Blv	Funeral	Home Inc lver Sprin	g,MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. CARDIO—RESPIRATO	RY_ARREST			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
b		ē	Sequentially list conditions, day, leading to immediate b. ATHEROSCLEROTIC Due to (or as a consequence of)	VASCULAR DISEASE			
	cuted	Examiner	flarly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Š	e exerian ar		resulting in death) Last Due to (or as a consequence of):				
68/6 0,	icate be executed physician and s the burial-transit	edical	d				
	ding p	-	IF FEMALE: 23c. If yes, outcome of pregnancy				
O. BOX	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?	B □Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
ري ح	s that med b e deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
cords	w requires that been signed b should be deta				1 □ Ye	s 2 No 3 Pro	obably 4 Hunknown
Z E	siclan: The law re certificate has be irector, page 2 sh	Completed			24a. Was au autops perform 1 Yes 2	y prior to c	topsy findings available completion of cause of
VITal	clan: ertific actor,	Be (25. Was case referred to medical examiner?		th Check on one	_	A
0	this ald	10	1 Tyres 2 No Hospital: 1 □ Inpatient 2 XER/Outpat			nce 6 Other (Spec	ify)
	De te	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe ho	w injury occurred	
INISION	st or Attanding after death. I Director: After d in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Str	eet and Number or Ru	ral Route Number,
5	2 4 4 6	Certification:	4 Homicide determined building, etc. (Specify)		City or Town	, State)	
	4 4 p 9	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month	
	8+1			D0057340	A)	PRIL 20, 20	005
	071		30. Name and address of person who completed cause of death (Item 23a) (Typ		NOMON DO	00/00/600	301
	Sta	te.	NEIL C. EVANS, M.D., VAMC, 50 IRVING 31. Date filed (Month, Day, Year) 32 Registrar's Signature		NGTON, DC	20422/688	
	Registr	-	31. Date filed (Month, Day, Year) APR 2 6 2005 39 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registra Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Year **Physician** Mary Helen Cropper April 2005 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salvally Micanico 11113419 MAD ICA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🔀 F Director 228-42-6927 94 June 30, 1910 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Completed by Funeral Director Wicomico Salisbury 10e, Street and Number 10g, Citizen of What Country? 10f, Zip Code 5897 Walston Switch Road 21804 U.S. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Black 3

Widowed 4 □ Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health and Mental Hygiene nt: if Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Domestic 8th various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Wallop Emma Handy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jenkins/daughter 5897 Walston Switch Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Tabernacle Baptist 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20 Department o Important: If any injury or once. Cemetery 5/1/2005 Horntown, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 04 /Medical Due to (o - a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 0 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1. Matural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P6952000 4/21/20 and address of person who completed cause of death (Item 23a) (Type, Print) D. V wion St, Law bury DYD J. 31. Date filed (Month, 32. Figistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Gladys April 2005 Μ. 8:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 577**-**03-3566 92 June 22, 1912 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28e-f ehow Maryland Frederick Frederick 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 E. 16th Street 21701 USA Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify. Specify: White þ 3 ∰Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Dieh1 Lena Metcalfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Woodbine Road, Woodbine, MD 21799 Nick Sweadner/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of Hi Important: if ites any injury or oth ans. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □Donation 5 □ Other (Specify) 4/26/2005 Johnsville UMC Cem. Johnsville, MD 22. Name and Address of Facility Stauffer FuneralHome, PA 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 Examon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown ed by the a signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been significant category. es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 🛛 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 → No P 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00145 E, 30. Name and address of person who completed cause of death (Item 23a) Type, Print) W. Cline, 300 West Ninth Street Frederick, MD 21701 Dr. Casper 31. Date filed (Month Propress) 32. Registrar's Signature 2005 State Registrar

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		For State	State of M		partment of I		Mental Hygi	ene nos	15763
		Registrar			ertificate of	Death	1	g. No.	10100
Physic	ian	Decedent's Name (First, Middle,	Last)	1	1		2. Date of Death Month	Day Year	3. Time of Death
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Funeral Director		None	10 M 2□F	Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year	hplace (State or Foreign untry)
		Usual Residence of Decedent				17	14-29	-03 14	anyland
nylan- how		10a. State 10b. County		10c. City, Town or	Location		-		10d. Inside City Limits
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death with the Maryland ms 23e or 28e-f ehow	Funeral Director	5 Oak Tree R	a.			.7353		USA	
er de Items	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
ours aft	byF	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give* Year or Dates:	No	1 ☐ Yes 2 No	Specify:		Specify:	h. H.
tura i		15. Decedent's		16a De	cedent's Usual Occup	nation	1 1	6b. Kind of Business/	
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ylding	To E	David L. D	onley			April	Appenze	eller	
if e, INIGITY IGITION A LATIONONON STAND S	ľ	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	ailing Address (Street	the same of the sa	-	City or Town, State, Z	Tip Code)
and and n 27		David L. D	onley, Fa	ther 5	Oak Tree	Rd., 0	rrtanna	, PA 173	53
Dallingle, and permit. Pages 1 and Department of Heal Importent: If Item 2 eny injury or other once.		20a. Method of Disposition 1 → Burial 2 □ Cremation	3 □ Removal from State	20b. Place of Dis	sposition (Name of rematory or other pla	ce)	Date 2	Oc. Location - City or	Town, State
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Demit. Depart Import eny inj	1	21. Signature of Funeral Service Li	ensee		22. Name and Addre	ess of Facility		s Funera	
70599		Jeffrey a	e /avo		12525 Бг	adbury	Ave., Si	nithsbur	g, MD 2178
		23a. Pan / E/tu/ ne di lase, or c show, er art fallere. List o	omplications that caused nly one cause on each li	the death. Do not ne.	enter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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Attending Physicien: The laver death, rector: After this certificate has by the funeral director, page 2	To B	examiner? 1 □ Yes 2 🕱 No	Hospital: 1 Inpatie	ent 2 ER/Outpat	ient 3 DOA Oth			ce 6 □Other (Spec	ifv)
neral		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time		y at	28d. Describe how		,,
eath. or: Af	atic	2 ☐ Accident investiga	tion	, , , , , , , , , , , , , , , , , , , ,	*	Yes 2 □No			
r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
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To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only Z Medical E)	Physician: To the best caminer: On the basis of	r examination and/or	ath occurred at the tir investigation, in my o	me, date and place,	and due to the cau	se(s) and manner as	stated.
the the mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.					
		100	11 1 10		29c. Licens			I. Date signed (Month	
Viil To		VM0. 0.	(/ 1 . 11 / /		1				
To To cor		Mauleal	Mulle	n		35141		4.30-0	
To Too		30. Name and address of person w			e, Print)				
1	ate		rederick N		e, Print)				

			1 - For State Registrar	State of Maryla		partment of I			giene (15764
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Las A. H. H. H. H. H. H. H. H. H. H. H. H. H.	DENNIS	6 E IAK	4b. City, Town,	or Location of D	2. Date of Dea Month	ath Day 35 3 4c. County	3. Time of Death 3. Time of Death 3. Time of Death 4. Of Death 4. Of Death 4. Of Death
	Funeral Director		5. Social Security Number 6. Se	7. Age (In y	rs. last birthda Z 6 Yrs.	/) If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birt fin. (Month, Dat	1798	Birthplace (State or Foreign Country) Maryland
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23e or 28e-f show other traumatic event, Ite Macical Exercises: as be notified at	rector	10a. State 10b. County Maryland Worces 10e. Street and Number		City, Town or l	n Pines 10f. Zip Code			10g. Citizen of \	10d. Inside City Limits 1 ☑ Yes 2 ☐ No What Country?
	eath with	erai Di	41 Falcon Bridge	Rd 12. Was Decedent Ever in	118 13	2181			USA	e - American Indian.
9036	ours after d rel', or Iten Examiner	d by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub		(Specify Yes or No- uerto Rican, etc.)	Specify	ck, White, etc.
21215-0036	l within 72 h jiene. r than "netu ine Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		(Giv	edent's Usual Occup te kind of work done DO NOT use retire	during most of	working		usiness/Industry aurant
Maryland 2	should be filed and Mental Hygis marked other	To Be C	17. Father's Name (First, Middle, Last) Hubert A. Hostett				Rebec		Maiden Suman	ne)
	1 and 2 sho Health and tem 27 is mother traum	State State of State	John H. Dennis/so 20a. Method of Disposition	n	41			Rural Route Number	Pines,	
Baltimore,	permit. Pages i Department of P Important: If ite any injury or ot once.		1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen.	Removal from State	alisbur	ematory or other pla y Cremato 22. Name and Addre	ory 4/	26/05	Salisb	ury, MD
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	dication, that caused the done cause on each line.	eath. Do not e	501 Snow nter the mode of dyi	Hill Ro	L., Salisb diac or respiratory ar	ury, MD	al Association 21804 Approximate Interval Between Onset and Death
8760,	/Medical Examiner b bhysician and to the bruial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						- Jyes
.O. Box 6	ne death certi the attending thed for use a	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time of 9□Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delivery onth Day Year
<u> </u>	w requires that the bod by should be detact	ed by Ph	Part II. Other significant conditions co	ontributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did to	,	ribute to the cause of death? 3 Probably 4 Unknown
Vital Records,		Completed						24a. Was autop perfor 1 \(\text{Yes} \)	med?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 275%
Z <u>i</u>	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner No	Hospital.	2 ☐ ER/Outpatio	Ott	ner.	Death (Check only of		(7)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation: To	27 Manner of Death Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Inju	4 🔲 Nursin	g Home 5 Resid		
Divis	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s	treet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) Certifying Phy	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, dea ination and/or	ith occurred at the ti nvestigation, in my o	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	cause(s) and ma date and place,	inner as stated. and due to the cause(s)
)	To th within To th	M	29b. Signature and title of certifier	1/10/	m	29c. Licens				d (Month, Day, Year)
•	Suf		30. Name and address of person who	mpleted cause if death (I	Item 23a) (Type		7621	8	1 1	6-05
	. Sta Registi	2.00	31. Date filed (Month, Day, Year) APR 2 7 2	32. 10 gistrar's Sf	griature	pole	<u> </u>	Deff()	8	5 00102

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** Year ERSHKOWITZ 23 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/26/1915 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director 212-09-1146 89 MARYLAND Usual Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 ☐ No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 Itеms 23a 6121 MONTROSE ROAD U.S.A.

14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Items 23e any injury or other traumatic event, the Wedical Example at must once. 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACOB FLAGMAN **JENNY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE TEPPER/DAUGHTER 15405 PEACH LEAF DR., N. POTOMAC, MD 20878 Date 20c. Location - City or Town 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) UNITED HEBREW CEMETERY 04/26/2005 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be axecuted burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.0. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? 21 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 SNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 🗌 Homicide 24 hours a Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the Barbara Kalazny, M.D. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Leloun 2 death (ttem 23a) (Type, Print) and address of person who completed cause of KOA MOR 31. Date filed (Month, Day, Year) State 26 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 05 1- State Registrar Amended #4ab per MD; FCHD Certificate of Death tm4/27/05 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0155 A.M. Catherine Rebecca Flora /Medical Apri 2005 4a. Facility Name (If not institution, give street and number) Washington 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro Hagerstown Fahrney-Keedy Home County Hospital Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M **Director** 220-42-6115 December 30, 1910 Maryland Usual Residence of Decedent the Maryland 10h Counts 10a. State 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Exeminer must be notified at Washington Boonsboro Maryland 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 21713 10g. Citizen of What Country? 8507 Mapleville Road U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: white 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virgie Mae Harris William Henry Nusbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5402 Hines Road, Frederick, Maryland 21704 Charlene Walter - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Cemetery 4/26/2005 Libertytown, Maryland 22. Name and Address of Facility 21. Sign were of Funeral Service Licensee Stauffer Funeral Home narow ene 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia 70 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liceace or injury Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρΛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 212 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 □ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/21/5 D52323 27.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 1126 Opal Court, Hagerstown, Maryland M. Khalid Waseem 31. Date filed (Month Day Year) 32. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gant Joseph Harvey 21, April 2005 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Gaithersburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2 F 58 Director 577-64-7295 3-8-47 Va. Usual Residence of Decedent be filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be retified at 1⊈Yes 2□No Director Md. Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18075 Royal Bonnet Circle 20886 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes **2** ☐ No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Unemployed permit. Pages i and 2 should be file.
Department of Health and Mental Hys, Important: If Itan 27 is marked --- any injury or other i--- once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Edward Gant Martha Ann Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) Edith M. Gant/Daughter 12001 Old Columbia Pike, #115 S.S., Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Crem. 4/28/05 Beltsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hackett's Funeral Chapel, Hacket W 814- Upshur Street, N.W. 23a. Pert1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Septic **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed ulmonar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai neumoni IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Denknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 1 Yes 2 ₩No 1 Yes 2□ No the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 | Yes 2 | 110 1 Impatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 ENatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a a Funaral C 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Shahyar Gharacholou, M.D.

APR 2 6 2005

31. Date filed (Month, Day, Year)

D61817

9901 Medical Center Dr. Gaithersburg, Md.

April 21, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [] 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 21 Natale Greco April 2005 8:24 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 □ F Months Hours 80 149-12-5556 Director 1924 Pennsylvania 4, Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event. It in Modical Examinal must be notified at Director 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8129 Langport Terrace 20877 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: by 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Gloucester County, NJ 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Orazio Greco Natala Berte ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8129 Langport Terrace Gaithersburg, Maryland 20877 Barbara S. Seubert / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Gate of Heaven Cemetery 2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 26, Ø Silver Spring, Maryland 4 Donatiβη 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the of ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanced Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transil the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page this certificate 2X No 1 🗆 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 XOther (Specify)Hospice1 ☐ Yes 2X No Certification: To ŧ 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 X Natural 5 Pending investigation death. 1 Tyes 2 No after death completely filled in by the 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 26

2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Rockville, Maryland 20855

Charles Harrison, M.D. 6001 Muncaster Mill Road

32 Registrar's Signature

margarei Goff 05-02931 RKD

Physic	ian	1. Decedent's Name (First, Middle, La	ast)						of Death	lay of	3. Time of Dea
/Medi		MARG		GOFF				APR	\perp 2	7°, 20ď	5 2:55P.
Exami	ner	4a. Facility Name (If not institution, given 5802 ANNAPOLIS RO				Town, or L DENSB	ocation of	Death	1	kc. County of I	Death GEORGES
Funeral Director		343-14-9706	Sex 7. Age 1 ☐ M 2 X ☐ F	(In yrs. last birthday 81 Yrs.) If Under Months		If Under 24 Hours	Min. (Mor	of Birth oth, Day, Yea	r)	Birthplace (State or For Country) ILLINOIS
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	.ocation						10d. Inside City Lie
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and N	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address	(Street an	d Number	or Rural Route	Number, City	or Town, Sta	ate, Zip Code)
alth alth 27 i 27 i 67 tra		RICHARD GOFF/	SON	517	JORDAN	N PON	D LA.	, BOWIE	, MD.	20721	
of Fig.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Demoval from State	20b. Place of Disp cemetery, cre				Date	20c.	Location - Cit	y or Town, State
rage nent ant: I		'4 □Donation 5 □Other (Speci		CHAMBER	S CREM	ATOR	Y 5-	3-2005	R	IVERDAI	LE, MD.
permit. Pages I Department of H Important: If its any injury or of once.		21. Signature of Funeral Service Life	nsee (, Z	2. Name and	Address	of Facility	HOME &	CREMA	TORTIN	1. P. Δ.
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be executed ician and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	consequence of):							
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ate has page 2	Completed							_	. Was an autopsy performed?	prior deat	e autopsy findings avail r to completion of cause th? Yes 2 \(\square\) No
ysician: In is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		f Death (Check			
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S 8 9	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	examination and/or in	th occurred anvestigation,	it the time, in my opin	, date and i	place, and due occurred at the	to the cause(time, date a	s) and manne nd place, and	er as stated. due to the cause(s)
le Hosp 124 hou le Fune letely fil	a a	29b. Signature and title of certifier	$\bigcap \Lambda$.		29c.	License n	number		29d. D	ate signed (N	fonth, Day, Year)
To the rospita or Attanding Fri within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ		17 1 /		1	0 0) (T		A DD "	TT 00	
to the hosp within 24 hou To the Fune completely fil	Σ	> Al Man	~ /V			O.C.	M.E.		APR.	IL 28,	2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:45 P Josephine R. Giacalone May 3, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 € F Yrs. Director 578-07-0069 December 22, 1913 Washington, DC Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rel', or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes XX No Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 West Tantallon Drive 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: White þ XXXVidowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker In Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygh.
Important: If tiem 27 is marked.
any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Marino Theresa Romeo ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles LoMedico / Personal Rep. 813 West Tantallon Drive Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery May 7, 2005 Clinton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature uneral Service Licensee alk 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a art 1. Inter the disease, or implications that finded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary **Physician** disease or condition resulting in death) /Medical Examiner overlog Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Cardiomyo resulting in death) Last attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2XXNo 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2XXNo 1 ☐ Yes 2□ No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9400 Livingston Rd MD Inderson 32. Registrar's Signature State

Registrar

		1 = For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of Hertificate of L			ene	5 15772
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ITE, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, it is Medical Examinational be notified at			wkins/Wife				ural Route Number, C		
rre, M s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Place of Disp					ity or Town, State
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hys this	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 □ Inpa 28a. Date of In	itient 2 ER/Outpatie		4 Nursing H	lome 5 Residence 28d. Describe how		
Jon on adding Figure 1: After a funeral	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month, E	Day Year) Injury	Work?	as 2 □ No	Edd. Describe flow	injury occurred	
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To ti To ti comp	Ž	29b. Signature and title of certifier			29c. License i	number	29d.	Date signed (Month, Day, Year)
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44		30. Name and address of person v				n	1 11 1	1 007	227
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eral ctor		5. Social Security Number 6. Security Number 145	7. Age (In yrs. 79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. I	, Year) 8, 19	25 Egyp	place (State or Fo intry) †
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Hullett **Physician** Duvall Charles Ma 2,200 9 01:25 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Garrett Mennonite Hume Gantsville Goodwill If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2□ F Director Aug 22, 1907 | Maryland 212-03-3146 Usual Residence of Decedent 97 permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Grantsville MD Garrett 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21536 USA 222 Killdeer Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Amoco/BP Oilburner Repairman 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Perkins Charles Hullett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26796 Garrett Hwy., McHenry, MD Sandra K. Savage, Step-daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Garrett Co. Memorial Gard, 05/04/2005 Oakland, MD 22. Name and Address of Facility Newman Funeral Homes, P.A., 179 21. Signature of Funeral Service Licensee Miller St, PO Box 275, Grantsville, MD 21536 Oums 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hanit Examiner Alzheimers Physiclan/Medical Examiner ementio attending physician and for use as the bunal-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medical Certification: To 1 ☐ Yes funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Director: After to d in by the funera 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter K. Naumann. M.D. DO Box 247 Accident MD 21520

32. Registrar's Signature

Elever St Apolle

2005

Registrar

			For State	State of Maryla	nd / Dep	artment of I	Health and N	•	•	15775
			Registrar		Ce	rtificate of	Death		eg. No.	
1	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yea	3. Time of Death
	/Medic	al	Wlliam Tildon Harn					M prul	23, 200	
4	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of De	
			Washington County 5. Social Security Number 6. Sex		s. last birthday	Hagersto	WIN If Under 24 Hrs.	8 Date of Birth	Washing	
	Funeral Director			M 2□F 70	Yrs.	Months Days		8. Date of Birth (Month, Day March 2	8.1935 V	Birthplace (State or Foreign Country) 11g1nia
			Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ylan		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	B Ma	cto	Maryland Washingt	on Ha	gerstow	m				1 ☐ Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What	
	ath w 23a	ra	9437 Crystal Falls			21740			United St	
	tems	nue		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	nerican Indian, hite, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □XYes 2 □ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
21215-0036	hour tural	pa pa	15. Decedent's Edu	Year or Dates:	16a Dece	ident's Heiral Oscii	nation	1	16b, Kind of Busine	no/leductor
15	in 72 nan" c	olet	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retire	pation during most of worked)	ring	TOD, KING OF DUSING	samuustiy
212	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		11 Opera		į	East Alc	0
þ	e file Hyg othe ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
lar.	should be find Mental B marked of	TOE	Robert L. Harner				Henriet	ta Harmo	n	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ms		19a. Informant's Name/Relationship (Ty	ре, Print)		-			r, City or Town, State	
	1 and 2 Health em 27 i		Virginia Harner/Wi		-	_		,Hagerst	own,Maryl	and 21740
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R			osition (Name of matory or other pla	ice)	Date	20c. Location - City	
Ë	Pages ment of h ant: if ite		' 4 ☐ Donation 5 ☐ Other (Specify)	R	esthave		i			, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at ODGs.		21. Signature of Funeral Service License	1 /					uneral Ho	-
	20 ± € 0	Ш	Drowley &	mily						land 21702
	Physician /Medical		23a. Part 1. Enter the disease or complishock, or heart ailure List only or Immediate Cause (Final disease or condition resulting in death)	Acute	Respo	ralon	fy luxe	or respiratory ari	Pulmonay Biotes	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a cons	equence of):	07 421	mic of a	Tuelini.	Representation	
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):	1 cm		The contract of the contract o	Dise	
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Pnen	nonia					
oʻ	te be execu ysician and te burial-tra	Exa	resulting in death) Last	Due to (or as a cons	equence of):					
760,	ate be exect ted hysician and he burial-transit	cal		d					-	
89	ng ph as th	Med	IF FEMALE:					-		
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1□Live birth 2□Fe		⊒Ectopic pregnand	ey .		23d. Date of Month	delivery Day Year
0.	the a	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□ Unknown	f death 5	Other (specify) _			Wishiri	oay roar
Q	hat the	Ph	Part II. Other significant conditions cor	atributing to death but not r	esulting in the	inderlying cause g	ven in Part I	23e Did to	hacco use contribute	to the cause of death?
Records,	The law requires that the death certifica tle has been signed by the attending ph page 2 should be detached for use as it				3				es 2 □ No 3 □	
20.	w requir been si should	ete						24a. Wasa	24h Wasa	autonas findinas available
Re	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed						autop: perfor	sy prior death	
Vital			25. Was case referred to medical				26. Place of Dea		2 1 No 1 Y	es 2 No
>	/sicia s cert direct	o Be	examiner?	fospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	hon		ence 6 Other (S	nacify)
of	g Phy er thi	n.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju			ow injury occurred	oony,
0	Attending Physician: r death. sctor: After this certific by the funeral director.	atlo	1 Natural 5 Pending 2 Accident investigation	(World), Day 1 Gaz)	піцату		Yes 2 □No			
Division	r Atte	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
D	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		/							
	Hospitai 24 hours a Funerei I tely filled	Medicai	(Check only 2 Medical Exami	sician: To the best of my k	nowledge, dea ination and/or ii	th occurred at the towerstigation, in my	ime, date and place, opinion, death occur	and due to the d red at the time, o	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c Licen	se number		29d. Date signed (Mo	onth Day Year)
	To Too		\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	U 1		250. 250811	1.0 5 5 V		4/2 1/2	
	X		30. Name and address of person where	moleted cause of death (tom 22a) /T	Print)	0,778		1/04/0	7
	O		30. Name and address of person where d	I A	Y) 1	Och Hi	U An	1+1x0 1	nd 21-	1/2_
	Sta	at <u>e</u>	31. Date filed (Month, Day Year)	32. Registrar's Sig	nature	1	11/12.	1		7 -
	Regist		APR Z 7 Z	UUD Johnson	I.	Grand)				

		•	For State Registrar	State of Ma	aryland /		irtment of H <i>tificate of l</i>		Mental Hy	giene Reg. No	000	15776	
			1. Decedent's Name (First, Middle, La	st)					2. Date of De			3. Time of Death	
	Physicia /Medic		JOHN THOMAS	HUNT					April		L, 2005	11:28 P M	
	Examin		4a. Facility Name (If not institution, give					Location of Death)	40	. County of Deat		
			FREDERICK MEMORI			146.4. 1	FREDER	RICK	100 10:		FREDERI		
П	Funeral Director		n/a	Sex /. Ag	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours Min. 27	8. Date of Bi (Month, Da April 2	ay, Ye <i>ar)</i>	005 Mar	hplace (State or Foreign ountry) yland	
	and *	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits	
	Aarylan f show	ō	Mareral and East-se	2.1		,	. 1					1 ☐ Yes 2√2 No	
	the 128a	Director	Maryland Freder 10e. Street and Number	ICK	Fre	eder	10f. Zip Code			10g. Ci	tizen of What Co	puntry?	
	3a or		6039 Quinn Road				21701			II	nited S	tates	
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No		14. Race - Ame	nican Indian,	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Medical Examinat must be ruitified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		Tes, specify Cubb	Specify:	o riican, etc.,		Black, Whit	hite	
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation	16	a. Deced	ient's Usual Occup	ation	kina	16b. K	(ind of Business	Industry	
21215-0036	2 should be filed within and Mental Hygiene. Is marked other then "eumatic event, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	n/a	kind of work done of DO NOT use retired	i)	na g	n/	a		
	il Hyg other	Be C	17. Father's Name (First, Middle, Las	")				18. Mother's Nan	ne (First, Middle	, Maidei	n Sumame)		
<u>lar</u>	uld be denta rkad ric ev	To B	John Thomas Tober	y III				Lorna Ni	cole Hu	nt			
Maryland	2 should land Menis marks		19a. Informant's Name/Relationship		1		g Address (Street			-		Zip Code)	
	and sealth m 27		L. Nicole Hunt /	Mother			Quinn Rd.	-					
Baltimore,	ges 1 t of H If Ita or otl		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [cemet	tery, crer	sition (Name of natory or other place	·	illate 25,		ocation - City or		
ţ	t. Pa rtmen rtent: njury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	-	Resth		Mem. Gar		2005			Maryland	
Bal	permit. Pages 1 and 2 Department of Health s Importent: If Itam 27 is any injury or other tre		21. Signature of Funeral Shares Lice	nsee		Re 95	Name and Address Sthaven 01 Catoc	Funeral S tin Mtn.	Services Hwy. Fi	s, Sl	kkot Cod rick, MI	ly P.A. 21701	
			23a. Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betty Onset and D										
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Intra	cravia	1 4	emorrh	age				27 minutes	
	/Medical Examiner		resulting in dealin)									2.7 years	
		4	Sequentially list conditions,	b. Ext	eme e a consequenc	e of):	ematur	ity				- i marana	
	uted d ansit	m	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
Ć.	ificate be executed g physician and as the burial-transit	Examiner	resulting in death) Last	C. Due to (or as	a consequenc	e of):							
68760,	ite be lysicië ne bue	edicai		d									
	≝ on rei		IF FEMALE:										
Вох	death certifii e attending p ed for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea		Ectopic pregnancy	,			23d. Date of de Month	livery Day Year	
	0 0 0	by Physician/M	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5	Other (specify)				1410.101	Jay 75	
P.0	that the	Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
Records,	as and as	d b					, ,		1 🗆	Yes 2	2 ⊠No 3 □ P	robably 4 Unknown	
00	w require been si	lete							24a. Wa	s an	24b. Were at	utopsy findings available completion of cause of	
	sicien: The law certificate has b irector, page 2 s	Completed							auto perf 1 ☐ Yes	opsy formed?	death?	completion of cause of	
ta	en: Tiffical	ø	25. Was case referred to medical					26. Place of Dea			0 12168	223110	
of Vital	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ⊠Inpati	ent 2 ER/	Outpatier	nt 3 DOA	er: 4 🗆 Nursing H	fome 5 ☐ Res	idence	6 ☐Other (Spe	ocify)	
<u> </u>	ng fter ne		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	Time of Injury	Wor	k?	28d. Describe	how inju	ury occurred		
sio	Attending r death.	cati	2 Accident investigate 3 Suicide 6 Could not	he -				Yes 2 □ No	201 1	(0)		18	
Division	a after of Direct of in by	Certification:	4 Homicide determine	280. Place of in	ic. (Specify)	tam, sti	eet, factory, office		City or To			ural Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	f examination	lge, deat and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occu	a, and due to the urred at the time	e cause(s	s) and manner as nd place, and due	s stated. e to the cause(s)	
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			* Kutherine	C. Whit	I MM		D2	8737		04	122/	2005	
			30. Name and address of person who	completed cause of white, M.	death (Item 23a	a) (Type,	Print)	ial Horani	tel 4m	W. 7	7 th St. F	rn. Day, Year) 2005 Fredenik, MD	
:	Sta Regist		31. Date filed (Month, Day, Year) APR 2 7	2005 32. Registr	rar's Signature	4	Consider 1	1 1/108/11	(mg 100				
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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2005 21, William Matthew Hambv April 2:09 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's 25715 Chaptico Hill Lane Chaptico 7. Age (In yrs. last birthday)

R5 Yrs.

Age (In yrs. last birthday)

Nonths Days Hours Min.

Nonth Days Hours Min.

Nonth Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Year 1920 Virginia Director 579-14-4285 Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ages I and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, tra Medical Examinat must be notified at 10a. State 1 Yes 2 No Funeral Director Maryland St. Mary's Chaptico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25715 Chaptico Hill Lane 20621 United States 12. Was Decedent Ever in U.S. Ammed Forces? 1 M Yes 2 □ No 1942 – If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Unions 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hilyard M. Hamby Mary Lucress Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 305, Chaptico, MD 20621 <u>Marian Hamby-wife</u> Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) MD Veterans' Cemetery 04-27-2005 Cheltenham MD 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Signature - Fun raf Service Licensee M01391 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer Lun **Physician** disease or condition resulting in death) /Medical Several Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Po Year in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. been signe should be d Completed by 1 Yes 2 No 3 Probably 4 ŪUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has rector, page 2 s autopsy 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Yeer) the funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after deat 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier Freberles 29d. Date signed (Month, Day, Year) 22 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD 20636-4871 Dr. David M. Federle, 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State APR 2 5 2005 Registrar

			1 - For State Registrar	State of Man			lealth and	Mental Hygie	2005	15778
	Physici	an	Decedent's Name (First, Middle, Later)	st)		timoato or i	Dour	2. Date of Death	Day Year	3. Time of Death
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7	Examir	ier	4a. Facility Name (If not institution, given Pineview Nurs	. 11		Clinto	Location of Deat	h *	Prince G	,
ì	. Funeral	24	5. Social Security Number 6. S	ex 7. Age (1	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9. Birth	place State or Foreign
Ľ,	Director		Usual Residence of Decedent	M 20F	73 Yrs.	World bays	710013		21,1932 West	Viginia
	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or Items 23c or 28a-1 show event, I're Medical Exacifer mast be notified at	or	10a. State 10b. County		Fort	cation	1,			10d. Inside City Limits 1 ☐¥es 2 ☐ No
	r 28a-	Funeral Director	10e. Street and Number	eurges	701	10f. Zip Code	run .	10g.	Citizen of What Cou	
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920	urs aft al', or Exami	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2℡No	Specify:		Specify:	La
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Maryland	should be nd Mental markad o	To B	Vaith		ackish		Elizab	eth ·	Tackish	
Mar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)	The second second	ng Address (Street a	and Number or Ru	iral Route Number, Ci	ity or Town, State, Zip	Code)
-	s 1 and if Health item 27 othar tr		Denay Hille 20a. Method of Disposition	/ Hwsanci	2503 20b. Place of Dispo	Sition (Name of	ICCI F	Date 200	c. Location - Chy or To	20777 own. State
m _o m	0 0 ====		1 ☑Burial 2 ☐ Cremation 3 ☐ 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Marya Lu	natory or other place		16-05 CI	hollerch am	MD
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	isee (22	2. Name and Addres	,	11 101	1	
			23a. Part1. Enter the disease, or com	plications hat caused the	191 /	Iclams F	uneral	Hume PA	Aguaro	MV ZOGOR
	Prysician /Medical		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one day e on each line. PER VO Due to (or as a co	XLZAQ)	TIC CA	HANOU	ASCURAN	DISEASE	Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		onsequence or,					1
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Вох 6	eath certific attending p	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of delive	env
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ ¥o 9 ☐ Unknown	1∐Live birth 2 ☐ 4☐Pregnant at tim 9☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the detached		Part II. Other significant conditions of	ontributing to death but n	ot resulting in the ur	nderiving cause give	en in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
Vital Records,	w requires been sign should be	ed by							1.4	ably 4 Unknown
eco	e faw requ has been je 2 shoul	ompleted						24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
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Division	2 0 5 ×	ertification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or Rura late)	l Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical C	Check only 2 Medical Exam	ysician: To the best of miner: On the basis of exa	y knowledge, death	occurred at the tim	e, date and place	, and due to the cause	e(s) and manner as st	ated.
	within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		22-1:				
	⊢ s ⊢ ŏ		110			0-1	8545	AP	RIL 22	2005
0	- 6		30 Name of ss of person who	completed cause of death	(Item 23a) (Type,	Print)	CICIN	en uva	DALE	1 7000
4	Sta	te.	31. Date filed (Month, Day, Year)	32. Resistrar's	Signature,	(1) L100	e caul	The WHI	word, held	d. 2005
5	Registr		APR 2 5 2	2005 Maria	Signature A	berle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Frederick Harold Horman 2005 Apri] 25 10:20 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Carroll Manchester If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 79 Yrs 472-24-7150 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in then "natural", or itama 23a or 28a-f show the Modical Examiner must be notified at Carroll MD Manchester 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3339 Kensington Square 21102 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ₹ Yes 2 No If Yes, Give Year or Dates: 1944 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Link (Singer Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. Int: if itam 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Simulators) 12 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Horman Lidia Whitting 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3339 Kensington Square Manchester, MD othari Honor Horman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/27/2005 1 □ Burial 2 Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. Carroll Cremation Inc * 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Fureral Service Licenses 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hows /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit been signed by the attending physician and should be detached for use as the hiring trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 1 ☐ Yes 2 ☐ Ne 1 ☐ Yes → No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 CNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

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The law requires that the death certificate ba executed

or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760

with the Maryland

filed within 72 hours efter deeth

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

General & Specific

30. Name and address versus who completed cause of death (lem 23a) (Type, Print)

32. Registrar's Signature

Ruen 31. Date filed (Month, Day, Year) 033165

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		1	For State Registrar	State of Maryland / Dep <i>Ce</i>	artment of Health and N ertificate of Death	Mental Hygier	2000 10100				
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 4.205				
	Physicia /Medic		Betty	Louise He	eavner	May 03,	2005 1335 p M				
	Examin	_	§a. Fecility Name (If not institution, give standard) Aspen Court	reet and number)	4b. City, Town, or Location of Death Middletown	1	4c. County of Death Frederick				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye					
	Director	-	214-42-1038 Usual Residence of Decedent	60 Yrs.		Aug. 10,	1944 Maryland				
	land low	_ ⊢	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits				
	Mar B-f s l	ito	Maryland Frederick	Middletown	n		1 ☐ Yes 2 🕅 No				
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?				
	s 23a		7301 Aspen Court	- 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	21769 Was Decedent of Hispanic Origin? (S	USA	14. Race - American Indian,				
36	i within 72 hours after death with the Maryland liene. I then "natural", or Itams 23a or 28a-f show Ita Medical Evanimet nest be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ▼ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White				
21215-0036	tural cal E	edt	15. Decedent's Educa	ation 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/Industry				
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22. Name and Address of Facility Kee 106 East Church St		asford Funeral Home derick, MD 21701				
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O. Box	e death certifica the attending phed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		B□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
σ.	requires that the de een signed by the a hould be detached f	Ph)	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?				
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	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowledge, de her: On the basis of examination and/or and manner stated.	best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	To the within To the comple	Me	29b. Signature and title of certifier	101	29c. License number		Date signed (Month, Day, Year)				
			Illam H	Koliser. A	D37197		May 04, 2005				
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ M.D., 15 West Seve	enth Street, Frede	rick, Mary	land 21701-4501				
	St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 1 0 2005	32. Registrar's Signature							

DHMH 17 Rev 1/2001

Registrar

istrar's Signature

	Registrar 1. Decedent's Name (First, Mic	dle, Last)				rtificate o	, Deaul		Date of Deat	h Day	Year	3. Time of	f Death
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iner	4 = 30, 11 (11	ion, give s	treet and nu	ımber)		4b. City, Town	, or Location o	of Death		4c. Co	ounty of Deat	h	
	2013 Marbury	-		- A - //-		Distri	ct Hei					George	
	5. Social Security Number 214–68–9428	6. Sex	M 2 1 €7F	7. Age (In yrs	Yrs.	Months Day		Min.	Date of Birth (Month, Day, une 29	Year)	9. Bin	hplace (State ountry) yland	or Foreig
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2	2013 Marbury	Drive				20747	-		"		S.A.	unity :	
PALA	11. Marital Status		12. Was Dec	edent Ever in l	J.S. 13.	Was Decedent of 1 Yes, specify C	f Hispanic Orig	gin? (Specif	fy Yes or No-		Race - Ame		
Ē	1 ☐ Never Married 2 🔀 M	arried		2 🔀 No	i			i, Puerto Ric	can, etc.)		Black, Whit		
by by	3 ☐ Widowed 4 ☐ Divorc	be	If Yes, G Year or [Dates:		1 □ Yes 2 X N	lo Specify:			Sp	Bla	ck	
Completed	15. Deced (Specify only high	ent's Educ	cation completed,)	16a. Deced	dent's Usual Occ kind of work do DO NOT use ret	cupation ne during most	t of working			of Business/		
m	Elementary/Secondary (0-12)	College	(1-4or 5+)									
		e Last)			Admi	nistrat:			it First, Middle, N		overnm	ent	
Be	i		ngton				Anna				iiiaiii9)		
Ľ	19a. Informant's Name/Relatio				19b. Mailir	ng Address (Stre					own State 2	Zin Code)	
	Mary S. Bauc					Marbur							207
	20a. Method of Disposition			20b.		sition (Name of natory or other p		Dat			tion - City or		
1	1 XBurial 2 ☐ Crematio 14 ☐ Donation 5 ☐ Other			TO TO		natory or other p Nation		4/29/0	15	Trior	nale V	irginia	,
	21. Signature of Funeral Servi) 1 4		2. Name and Add							1
		X		/ _		474 Lan							
ai Examiner		Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1								23d	23d. Date of delivery Month Day Year		Year
Ph	Part II. Other significant cond	tions con	tributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use	contribute to	the cause of d	leath?
d by									1 ☐ Ye	s 2 🗆 N	No 3 Pr	obably 4	Jnknov
Completed									24a. Was ar	1 2	24b. Were au	topsy findings	availab
E									autopsy perform	y ned?	prior to death?	completion of c	
CO		cal					26 Place	of Dogth //	1 Yes 2	X No	1 🗆 Yes	2 X No	
OB	examiner?		lospital:	Inpatient 2	☐ ER/Outpatien	it 3 DOA	Teh on		5 A Reside		Other /Sner	7(6/)	
12			28a. Date		28b. Time of Injury		jury at vork?		d. Describe ho			-11Y)	
atio	1 X Natural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(7070)	ini, Day rear)	Hijary		☐Yes 2☐N	No					
Certification:	3 Suicide 6 Cou 4 Homicide dete	3 Suicide 6 Could not be 28e Place of Injury - At home farm st					reet, factory, office 28f. Location (S City or Tow				(Street and Number or Rural Route Number, wn, State)		
Medicai		ing Phys al Examir	1er: On the l	e best of my kn basis of examin nner stated.	owledge, death ation and/or in	occurred at the vestigation, in m	time, date and y opinion, deat	d place, and th occurred	d due to the ca at the time, da	iuse(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
1 9	29b. Signature and title of cert	fier	1			29c. Lice	nse number		29	9d. Date s	igned (Montl	n, Day, Year)	
3													
2	- Ense-	_/	In R	andt	mo-	T	0448	3		GA	125/2	005	

State of Maryland / Department of Health and Mental HygieRe[] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, **Physician** Priscilla Alberta Jackson 0850 M 2005 /Medical Facility Name (If not institution, give street and nymber) 4c County of Death 4b. City, Town, or Location of Death **Examiner** Georges Chever(5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV. II, I 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 ₩ F Wash., Director 577-68-1430 54 Yrs. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumatic event. The Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5414 B St., S.E. 20019 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 12 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Percy Jackson Jannie Clark 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5414 B St., S.E. Wash., DC 20019 <u> Jannie M. Jackson - Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other steels). 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 4/29/2005 ` 4 ☐ Dor ation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Fureral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio VAScular Hort Discas Immediate c se (Final disease or condition resulting in death) Atheroscherotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examinet? Be 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 ER/Outpatient 3 DOA Certification: To in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) SALVADOY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 7 2005 Registrar

			1 - For State Registrar		partment of Health and ertificate of Death	Mental Hygie	2000 10/84
	Physici /Medic		Decedent's Name (First, Middle, Last) Phyllis Joann	e Jones		2. Date of Death Month April	Day Year 21. 2005 12.171
	Examir		4a. Facility Name (If not institution, give street and r	umber)	4b. City, Town, or Location of Dea		4c. County of Death
			9720 Huntley Drive		La Plata		Charles
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min		ear) 9. Birthplace (State or Foreign Country)
L	Director		Usual Residence of Decedent	71 Yrs.		August 2	
	land W		10a. State 10b. County	10c. City, Town or I	_ocation		10d. Inside City Limits
	Many	ō	MD Charles	La I	Plata		1 ☐ Yes 2 🏹 No
	28a	rec	10e. Street and Number		10f. Zip Code	10a	Citizen of What Country?
	3e of	Funeral Director	9720 Huntley Drive		20646		USA
	death	nera	11. Marital Status 12. Was De	cedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
9	after or ite	F	1 Never Married 2 Married 1 Yes	ZX No		по нісап, etc.)	Black, White, etc.
5-0036	72 hours after death with the Maryland naturel', or items 23e or 28e-1 show likel Evantrat must be redified at	d by	3 Widowed 4 Divorced Year or	Dates:	1 ☐ Yes 2 No Specify:		Specify: White
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2121	within ene. than "	dmo	Elementary/Secondary (0-12) College	(1-4or 5+)	Homemaker		Home
	filed Hygid ther		17. Father's Name (First, Middle, Last)			me (First, Middle, Ma.	
Maryland	2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "neturel", or items 23e eumatic event, the Medical Examiner mant	To Be	Joseph Ciarmataro			nia Carp	,
ary.	should nd Men marke imarke	1-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number or R		
	and 2 salth a n 27 is		Melvin Jones/Husbar		0 Huntley Driv		
ore,	ss 1 a		20a. Hethod of Disposition	20b. Place of Disp			c. Location - City or Town, State
Ē	Pages nent of ant: if it ary or o		↑ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State	d Veterans 4/2	7/05 Ch	eltenham, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23e or 28a-1 show any injury or other treumatic event, the Medical Examinat must be retified at once.		21. Signature of Funeral Service Licensee	M09954	22. Name and Address of Facility AREHART – ECHOL	C FIMEDA	I HOME D
_	89778		Hours C. We	01	P-Q ROY 567	IA DIAT	A MD 20646
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	caused the death. Do not eleach line.	nter the mode of dying, such as cardia	c or respiratory arrest	Interval Between
	Physician		Immediate Cause (Final disease or condition	claro denm	α		Onset and Death
	/Medical Examiner		resulting in death) Due t	o (or as a consequence of):			1
		-	Sequentially list conditions, b.	o (or as a consequence of):	ibrillation		
	ited nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence or).			
,	cate be exacuted physician and the burial-transit	Examiner	resulting in death) Last C. Due t	o (or as a consequence of):			
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9	rtifica ng ph as th	a	(FERMALE)				
Вох	th ce tendii or use	an/I	200. Was decedent pregnant	utcome of pregnancy birth 2 Petal death 3	□Ectopic pregnancy		23d. Date of delivery
	The law requires that the death certifit to has been signed by the attending to agge 2 should be detached for use as	Physician/M		gnant at time of death 5	Other (specify)		Month Day Year
P.0	hat th d by detacl		Part II. Other significent conditions contributing to	don't but not enculting in the	maliation and the Pool (22a Didashar	
ds,	uires thai signad I d be det	Completed by	Sclero der ma	dodar but not resulting in the	// +1		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☒Unknown
Records,	w requir been si should	etec	Paris d'id Ci	at's p	6 15		
Rec	The law	mpi	pericardial fabri	1513 K	aynauds-	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a			Thyraid ax.		steopenia	1□ Yes 💥	No 1 Yes 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Y} \text{No} \) Hospital:	Inpatient 2 ER/Outpatie	Other	ath (Check only one)	
of		n: To	27. Manner of Death 28a. Dat	e of Injury 28b. Time	of 28c. Injury at	28d. Describe how	e 6 Other (Specify) injury occurred
ion	Attending I r death. ector: After by the funer	atio	X Natural 5 Pending (MC 2 Accident investigation	nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	r Attendi er death. rector: A by the fu	tific	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, s ding, etc. (Specify)	treet, factory, office		et and Number or Rural Route Number,
Ö	tel or rs afte el Dir	Certification:	Tomoso But	unig, etc. (Specify)		City or Town, S	naie)
	lospi t hour uner		29a. Certifier Certifying Physicien: To the	ne best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the caus	se(s) and manner as stated.
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	and ma	nner stated.			
	To To		29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year) April 25, 2005
<i>(</i> .			Belle, MO		10006278	/	
1	RIE		30. Name and address of person who completed ca Betty Siu, M.D. 3150	Old Washin	aton Pd Suite	100 1.7.1	dorf MD 20602
11)U (I) Sta	te	31. Date filed (Month, Day, Year) APR 2 5 2005 32.	Poistrar's Signature	hade	100, Wal	HOLL, FID 20002
	Regist		APR 2 5 2005	gowe so			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day APRIL 24, 2005 Gary Kenneth Johnson 8:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 X M 2 □ F 62 472-46-6105 Yrs. Minnesota Director ĭ943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 🗷 No Delaware New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Aldershot Drive 19713 or Itams 23s U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give 1 0.6.1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Year or Dates: 1961-65 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Self-Employed Artist Artist d 2 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Richard Johnson Gloria French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Isaac Johnson (son) 19 Honeysuckle Drive, Newark, Delaware 19702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ASCremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 04/27/05 ^ 4 □ Donation 5 □ Other (Specify) West Chester, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PROBABLE ACUTE MYOCARDIAL INFARCTION MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE LUNG DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No **ASTHMA** autopsy performed? 1 Yes 2**X** No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D24648 APRIL 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 SHER A. HASHMI, M.D.,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND

			For State Registrar	State	of Mary		artment of rtificate of		and M	ental Hy	giene Reg. No	O U	5	157	86
			1. Decedent's Name (First, Middle	, Last)						2. Date of De				3. Time	of Death
	Physicia		Linda	Bartoo		Kelly				Month April	23, Da	y 2005	Year		6:00pm
}	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town,	or Location o	f Death		40	. County o	f Death		
			Mariner Healt	h-Betheso	đa		Bethe	esda				Mont	gome	erv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday	If Under 1 Year			8. Date of Bi	rth		9. Birtho	place (State	or Foreign
	Director		213-44-7370	1 ☐ M 2 🔼 F		60 Yrs.	Months Days	Hours	Min.	July 8	, 19	44	Coui Nash	niny) ingto:	n, DC
	P.		Usual Residence of Decedent												
	show		10a. State 10b. County		10	c. City, Town or L							1	10d. Inside (-
	Ba-f.	cto	Maryland Mon	tgomery		Silve	r Spring							1 (Ye:	s 2 No
	or 24	Oire	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of W	hat Cou	ntry?	
	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural, or Itema 23a or 28a-f show ther, the Medical Exammer must be confilled at	Funeral Director	1627 Belvedere	Boulevai	rd			20902					US	SA	
	r dec	ine	11. Marital Status	12. Was Dec Armed F		r in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Original	gin? (Spe	city Yes or No Rican, etc.)	0-		- Americ	can Indian, etc.	
ဓ္တ	or it		1 Never Married 2 Marri	If Yes, G	2 █No ive		1 ☐ Yes 2 🎦 No	Specify:				Specify:		ite	
21215-0036	urai	d by	3 ☐ Widowed 4 🍎 Divorced	Year or I	Dates:										
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22	Hygie Hygie ther nt,		17. Father's Name (First, Middle, I	1		10	r poimer v			(First, Middle	1				
au	ntal led o	Be	Louis Bartoo							Tinnel		Dumame	7		
Maryland	d Me d Me mark matic	2	19a. Informant's Name/Relationsh	nin (Tyne Print)		19h Mai	ing Address (Stree					or Toum S	State Zie	n Codel	
₹	d 2 s th an 7 is i		Carolyn P. Bar		or.		7 Belved				-				2002
a)	1 an Heal em 2 ther		20a. Method of Disposition	000, 2100.		Ob. Place of Disc	osition (Name of	- 1						own, State	1902
چ	of F H		1 Burial 2 Cremation		State	cemetery, cre	matory or other pla emorial Par		_	L 27,					
Baltimore,	it. Partrant		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		1,			i	200					Maryla	nd
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Exart are must be indifficed at once.		- Challen		ole	F 5	rancis J 700 Univer	sity l	ins i	Funeral	l Hon	ne In r Spr	c. ing,	, MD 2	20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the each line.	death. Do not er	iter the mode of dy	ing, such as	cardiac o	r respiratory a	arrest,			Approxima Interval Be	etween
	Enysician		Immediate Cause (Final disease or condition	Und	iffere	entiated	Carcinon	na					10	Onset and	
	/Medical Examiner		resulting in death)	-		onsequence of):								5 1101	CIID
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	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a co	onsequence of):									
	and tran	каш	that initiated events resulting in death) Last	C. Due to	/05.00.0.00	onsequence of):									
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9	death certific attending p		IF FEMALE:	23c. If yes, or	steame of a	foggaga.									
Вох	death certifi e attending id for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2	Fetal death 3	Ectopic pregnan	су				23d. Date Mon		ery Day	Year
0	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time nown	e of death 5	Other (specify)							,	
Δ.	that the death led by the atter detached for i		Part II. Other significant condition	ns contribution to	death but no	ot resulting in the	inderhing cause g	wen in Part I		23e Did	tobacco	use contri	hute to t	the cause of	death?
Vital Records,	26 75 00	l by	End-Stage Mul				andonying oddao g	.voiriir airi.			Yes 2			bably 4	
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ec	a 8 2	ldu								24a. Was	psy	pı	ior to co	opsy finding: ompletion of	s available cause of
E	Th ate pag	Co								1 ☐ Yes	órmed? 2 K No		eath? Yes	2 🗆 No	
/its	Physician: T this certificate ral director, pe	Be	25. Was case referred to medical examiner?	Magazitak					of Death	(Check only	one)				
of	S S D	၉	1 Yes 2 No			2 ER/Outpatie	TIL SU DOA			me 5 Res	-			fy)	
Ē		on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	9	of Injury nth, Day Ye	ar) 28b. Time Injury	W	ork?	1	28d. Describe	how inju	ry occurre	d		
<u>S</u> .	teal feal tor: the	cat	2 Accident investig	not be				Yes 2 1		201	/0.				
Division	in the	ertification;	4 Homicide determ	ined 286. Plac	ding, etc. (S	At nome, farm, s Specify)	treet, factory, office)	1	28f. Location City or To	wn, Stat	na Numbe B)	r or Hura	al Houte Nu	mber,
	Hospital or At 4 hours efter of Funeral Directely filled in by	O	29a. Certifier 1 X Certifyin	a Physician: To the	o bost of	us les aude des	th comment at the								
	Hos Fun ely	edical	(Check only one)	g Physicien: To th Examiner: On the and ma	basis of exa nner stated	amination and/or i	nvestigation, in my	opinion, deal	d place, a	and due to the ed at the time	cause(s , date an) and mar d place, a	ner as s nd due t	o the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	•			29c. Licer	se number			29d. Da	ite signed	(Month,	Day, Year)	
(1		· mu	, Stir	W-	m -		005177	79		Apr	il 2	5, 2	2005	
(78		30. Name and address of person	who completed cau	use of death	(Item 23a) (Type	, Print)								
			William J. Cu	llen, M.	60	000 Exect	tive Blv	d., #3	300,	Rockvi	lle.	MD	2085	52	
	Sta		31. Date filed (Month, Day, Year)	2005	Registrar's	Signature April	uli			_ + ***					
-	Regist	ar	HTK & b	7003 M	Was	10. W									

			Please 1	Type or Print in				-			
			For State Registrar	State of Mary		tificate of I			g. No.	5 15787	
38	Physici /Medic		1. Decedent's Name (First, Middle, Las Dorothea Louise	() Keesee	***			2. Date of Death Month April 2	Month Day Year		
	Examin		4a. Fecility Name (If not institution, give Northampton Manor			4b. City, Town, or	Location of Death		4c. County of De Frederi	eath	
	Funeral Director		5. Social Security Number 6. Se		yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 28,	0.5	Birthplace (Stete or Foreign Country) rkansas	
	yland sow		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits	
	8a-f st	Director	Maryland Frederic	k F	rederick				1 X Yes 2 □ No		
	3a or 2	I Dire	10e. Street and Number 200 East 16th Stre	et		10f. Zip Code 21701			g. Citizen of What	Country?	
36	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show to Medical Examirer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
5-00	72 hou natura	eted	15. Decedent's Ed (Specify only highest gra		(Give	ent's Usual Occupation kind of work done during most of working			16b. Kind of Business/Industry		
21215-0036	within ene. then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Wait1	DO NOT use retired	1)		estauran	r	
	e filed al Hygi I other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			
Maryland	Ments Ments Marked Marked	T _O	Gene Hammons	Con Print	405 14-17		Tommie M		O'r T Or -	T-0-41	
Mar	nd 2 st atth and 27 is n r traun		19a. Informant's Name/Relationship (1) Kerry Keesee/son	ype, Pnnt)			ad Chambe			e, Zip Code)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐		Ob. Place of Dispo cemetery, crer	sition (Name of natory or other place	æ) Apri	Date 26,	0c. Location - City	or Town, State	
Iţi			* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral, Service Licen) [el Cremat			denton, 1		
Ba	Depa Impo any ir		Bevely L	16 (-111		-	ss of Facility Crematic Heckrott			Box 784 11e. MD 2102	
	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a. Chronic Ol Due to (or as a co	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death Years	
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter I indentying	b. Due to (or as a co	nsequence of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C							
.O. Box 68	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of print 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year	
Δ.	juires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib							
Records,	9 4 9	Completed						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of ?	
of Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one)		
n of	ng Phys fter this ineral di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	y at k?	ome 5 ☐ Resider 28d. Describe how	nce 6 Other (S w injury occurred	pecify)	
Division	or Attendate death	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury -	M 1 Tes 2 No						
	Hospitel 24 hours a Funeral etely filled	edical Co	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exan	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	2/200		29c. Licens			d. Date signed (Mo	onth, Dey, Year)	
			1/60			-	2649	7 Ap	ril 25,	2005	

State Registrar

31. Date filed (Month, Day, Year)

Ronald E. Miller M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3601 Gillis Park Rd. Mt. Airy, MD 21771

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who o

31. Date filed (Month,

cause of death (Item 33a) (Type, Print

strar's Signature

State of Maryland / Department of Health and Mental Hygier@ [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Monti **Physician** 3140HOL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY NATH NOW MKOMA KARK TIMISVICTE HUSZITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 M 2X F 578-38-7787 74 Yrs. April 23,1930 North Carolina **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28e-f show the Medical Ever instrumst be notified at 1X Yes 2 □ No District of Columbia Washington Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 2001 - 15th Street, N.W.; Apt. 302 20009 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** Specify: þ 3 Widowed 4 Divorced naturei Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) then College (1-4or 5+) U.S. Post Office Mail Handler 12th grade other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental F pe permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumetic evone. Culbreth ၉ Maurice Williams Lucy Alvin 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 6013 Eastern Avenue; Apt. 10; Hyattsville, Maryland Marilyn Betsy Williams Prince April 27,2005 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Harmony Memorial Park Landover, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 an Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL NEARC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year ned for 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: No No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Mann f Death 1 atural After Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 10. Name a m 31. Date filed (Month, Day, Year) Registrar's Signature State 7 2005 APR 2 Registrar

		1	State of Maryland / Department of Heal 1 - State Registrar Certificate of Dec		ntal Hygie	. 000	15790
	# 7		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Marguerite H. Linn		pril 24		1:35 ^{a M}
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local	cation of Death		4c. County of Death	
6.			Montgomery General Hospital Olne		D + -(B) #	Montgome	
	Funeral Director			lours Min.	Date of Birth (Month, Day, Ye pril 3,		place (State or Foreign intry) Ohio
	pur *)-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryla f sho						1 ☐ Yes 2X No
	the N	20 -	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	intry?
	3a or		3555 S. Leisure World Blvd, #2A 20906	6		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hydiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28e-f show entry injury or other treumetic event. It is Machinal Examinal must be notified at once.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No If Yes 3 □ Widowed 4 ☒ Oivorced		y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
215-0036	thin 72 hou e. en "neture w. ciral E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	ng most of working	161	o. Kind of Business/I	ndustry
7	ed wi ygien yer th	Sol	12 Medical Secre	etary . Mother's Name <i>(F</i>		hysician'	s Office
and	be fill htal H ad oth	Be					
Maryland	d Mer narke	္	Michael Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and I	Harriet M Number or Rural R			ip Code)
<u>a</u>	d 2 st th and t7 is r treur		Michael L. Facine, Sr./ Son 5771 Box Elder C				
ore,	or of there		20a. Method of Disposition 1 Burial 2 Communication 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place)	April	25,	c. Location - City or	Town, State
Baltimore,	epartmer epartmer nportent ny injury nce.		21. Signatur of Funeral Service Licensee 22. Name and Address of Francis J.	200 of Facility Collins F	11-1	exandria, Home Inc	Virginia
<u> </u>	20E 29		23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, su	ity Blvd.	W. Sil	ver Sprin	Approximate
	Pnysician /Medical Examiner		23a. Part : Enter the disease, or complication that caused the death. Do not shell the mode of dying, so shock, or heart failure. List only one cau e on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIO SCI ENDTC CAMPONIC CAMP				Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Aprily)				
68760,	ficate be executed physician and is the burial-transit	ai Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
687	tificate ng phys as the	edicai	U			F	
.O. Box	attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of deli Month	very Day Year
٥.	uires that the d i signed by the id be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.		cco use contribute to	the cause of death?
Records,	The law requirate has been sipage 2 should	Completed			24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
Vital	certifica rector, p	Be C	evaminer?	6. Place of Death (0	Check only one)		
of V	sir sir	2	1 Yes 2 No 1 Inpatient 2 ► ER/Outpatient 3 DOA	-		ce 6 Other (Specialized	cify)
n c	ing P	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury at Work? (Month, Day Year) 28b. Time of Injury at Work? 1 Yes	s 2 🗆 No	d. Describe how	injury occurred	
Division	or Attend ter death irector: /	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical Ce	29a. Certifier (Check only (Ch	date and place, and ion, death occurred	d due to the cau at the time, date	se(s) and manner as a and place, and due	stated, to the cause(s)
	o the lithin 2.	Medi	one) and manner stated.		290	I. Date signed (Mont	h, Day. Year)
	15		Dame a. Moon, my		*	tpril 2	4, 2005
_			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thinks A - LUSSI, 3305 N. Leisune World RLVD, 31. Date filed (Month, Day, Year) APR 2 6 2005 3 Registrar's Signature	SILVER	1 princ	-, mo:	20906
*45	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2005 3. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygier [] [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2005 April Agustina 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Waldorf Healthcare Center Charles Waldorf | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 2, 1916 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Yrs. Director 052-24-4949 Puerto Rico 88 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "neturel", or Items 23e or 28e-f show the Medical Examinat must be notified at 1 Yes 2 No Maryland Charles Waldorf Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 Old Washington Road 20601 Puerto Rican death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene importent: if Item 27 is marked other than "neturel", or Item any injury or other traumatic event, the Medical Experiment 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Puerto Rican Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juan Perez Eustaquia Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5717 Bent Tree Lane, #401, Centerville, VA 20121 Franklin Lopez-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** 04-22-2005 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home M01391 P. O. Box 156, Waldorf, MD 20604-0156 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardovascular /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be exect Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🗆 🔻 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ths Hospitel within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22574 02 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. R. Timothy Pace, 12070 Old Line Center, #202, Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 1 per Dr., 6844, 06/06/1054bb f Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year P Physician APR 20 1:32 REGINA LOMINAC 2005 Carol H. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 💢 F 50 June 6, 1954 Director 408-98-1084 Tennessee Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State if Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Charles Waldorf the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20603 United States 5101 Flier Court Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 (AYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Benjamin Hutcheson Betty Bush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5101 Flier Court, Waldorf, MD 20603 Steven L. Lominac-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 04-27-2005 Arlington, VA 21. Signatu/ of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home M00053 P.O. Box 156, Waldorf, MD 20604-0156 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician NON-HODGKIN'S LYMPHOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, use as JF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ X o 1 patient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 ☐ Natural Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Tes 2 No death. 2 Accident investigation after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 24 hours a 29a. Certifier 1 Printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical sompletely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 21 2005 MD RES-000 APRIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LAWRENCE OSEI BETHESDA MD 20889-5600 32. Restrar's Signature 31. Date filed (Month, Day, Year) State APR 25 2005 Modera Registrar

amend item#14, 18, per FH, G843, 5/27/05 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Earl Robert Lowman 2005 11:00 A April 23, /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner 6551 Eden Mill Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Months Days Hours Min. July 13, 1 Woodbine Carroll 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F Director 705-12-2619 1917 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits rai', or frems 23a or 28a-f ehow Exeminer must be nutified at 1 ☐ Yes 2X No Directo Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mantal Hygiene.
ant: If item 27 is marked other than "netural", or Items 23a or 2 ury or other traumatic event, the Medical Exercines must be in 6551 Eden Mill Rd. 21797 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? tx□Yes 2 □ No If Yes, Give Year or Dates₩₩∏∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, WBlack 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Ď 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th MD State Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame)

Martha Gasaway 17. Father's Name (First, Middle, Last) Be John Lowman Gladys M. Dance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other training once. Mohammed B. Said 105 Marshall Wood Rd. Reisterstown, MD 21136 (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State White Rock Cem. April 27, 2005 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Purrier-Queen Funeral Home and Crematory, P.A. 1212 West Old Liberty Rd. Winfield, MP 2178/ Ht. Poller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) foiline Priysician heart Confestive 3 weeks /Medical Due to (or a consequence of): Examiner Coronory
Due to (or as a consequence of): 055000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ baan sig should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an page 2 s 2 No certificate 1 ☐ Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ÷ his After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral Completely filled it 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptific 29c. License number D05057174 WJL 2+14A 30. Name and address of person v no completed cause of death (Item 23a) (Type, Print) Zaft 1380 Progress way Suite 106 31. Date filed (Month, Day, Year) State APR 2 7 2005 Registrar

DHMH 17 Rev 1/2001

		4	For State Ragistrar	State of Maryland		artment of tificate o				giene Rag. No.	105	157	9 L
	Physicia	an	1. Decedent's Name (First, Middle, Last)						. Date of Dea Month		Year	3. Time of E)eath
	/Medic		Eulalia J.	McGee					pril	23	2005	5:57	РМ
	Examin	er	4a. Facility Name (If not institution, give s Shady Grove Adve		.	4b. City, Town	n, or Location o	of Death			inty of Death ntgome	257	
	-		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Ye		24 Hrs. 8	Date of Birt				Foreign
	Funeral Director			M 2XF 80	Yrs.	Months Da		Min.	Date of Birth (Month, Da) ug. 28	y, Year) - 192	4 Ind	place (State or ntry) iana	roreign
	ס		Usual Residence of Decedent						ug. 20	, 152			
	anylar show		10a. State 10b. County		Town or Lo		1					10d. Inside City 1 ☐ Yes	
	8a-f	ecto	Maryland Montgomer	у мо	ntgome	ery Vil							242 140
	a or	Funeral Directo	10e. Street and Number 18700 Walkers Cho	tan Pond #305		10f. Zip Cod	886				of What Cou d Stat	•	
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ğ	72 hours after death with the Maryland netural', or Items 23a or 28a-f show Iteul Exacultur Dust be motified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		l□Yes 2.KΩl	No Specify:			Spe	ecify: Wh	ite	
21215-0036	"netu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give	lent's Usual Oc kind of work do OO NOT use rei	cupation one during mos	t of working		16b. Kind o	of Business/In	dustry	
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d 2	filed Hygie other ant,	CC	17. Father's Name (First, Middle, Last)		Home	lakei	18. Mothe	er's Name (First, Middle,				
/lan	Mental Mental arked c	To Be	Wladyslaw Borkows	ki			J	losefa	UN	AVAIL	ABLE		
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Baltimore,	or other		20a. Method of Disposition 1 ☐ Burial &X Cremation 3 ☐ R	cor	ce of Dispo	sition (Name of natory or other p		Dat April		20c. Locati	on - City or To	own, State	
ţ	t. Pac rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify)	Metr		tan Cre	matory	2005	5			Virgi	nia
Bal	permit. Pages 1 Department of H Important: If Its eny injury or og		21. Signative of Funeral Service License	W	10	. Name and Ad E. Dee	er Park	Dr.		ersbur		20877	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	eations that caused the death.	Do not ente	er the mode of o	dying, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Dulmor	731	1 en	nbal	SM	1			Onset and De	
	/Medical Examiner			Due to (or as a conseque	ence of):)		- 11	(
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•	death certificate be executed e attending physician and ad for use as the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseque	ence of):			-					
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Вох	th cert endin r use	an/M	230. Was decedent pregnant	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregna	Incv			23d.	Date of delive		
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rds	w require been sig should b	ed b	Small bowel o	ostruction	surgi	St. 7			1 □ Y	es 2 N	3 □ Prob	oably 4 □Un	known
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Ö	s after all Dire	Certification:	4 Homicide	building, etc. (Specify)					City or Tow	m, State)			
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the restigation, in m	e time, date an ny opinion, dea	d place, and th occurred	due to the c at the time, c	ause(s) and date and plac	manner as s ce, and due to	tated. the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier	000		29c. Lice	ense number		2	29d. Date sig	gned (Month,	Day, Year)	
•			トノた	1 Johnson	_	D	. 30	148		Apr	112	7 20	05
_	1541		30. Name and address of person who co	inpleted cause of death (Item 2	23a) (Type, I	Print) III Rus	sell A	ve.	Gzit	hers	burg	17-02	79
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 6 2005	Registrar's Signatu	FORA.	le							

			For State Registrar	State of Maryland /		ent of H			giene Reg. No.	5 15795
	Physicia		Decedent's Name (First, Middle, Last)	FALSH				2. Date of De	nath Day	Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	eet and number) HOLPIT	AL J	SETT	Location of Death	7	4c. County o	tomer7
	Funeral Director		5. Social Security Number 6. Sex. 449-34-0662 1X	7. Age (In yrs. last)	Yrs.	nder 1 Year iths Days	Hours Min.	8. Date of Bir (Month, Da 10/30/		9. Birthplace (State or Foreign Country) IASHINGTON, DC
	death with the Maryland ms 23e or 28a-f show	tor	10a. State 10b. County MARYLAND MONTGOMERY	10c. City, To	own or Location	1				10d. Inside City Limits 1 No 2 □ No
	with the	Direc	10e. Street and Number 10500 ROCKVILLE PIK	F #425	10	f. Zip Code	5.2		10g. Citizen of Wi	•
36	after or Ite	by Funeral Director		2. Was Decedent Ever in U.S. Amed Forces? 1 K Yes 2 No If Yes, Give 1943-46			spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		- American Indian, , White, etc. WHTTE
21215-0036	"netur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16 completed) College (1-4or 5+)	6a. Decedent's (Give kind of life. DO NO	of work done of OT use retired	luring most of worl		16b. Kind of Bus	
Maryland 2	be filed Ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) SHEA J. MENSH	Σ Τ Γ.	STCHOLO		18. Mother's Nam		, Maiden Surname)
lary	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Typ			dress (Street a	and Number or Ru		er, City or Town, S	tate, Zip Code)
Baltimore, N			LILA MENSH/P.O.A. 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Re 4 Donation 5 Other (Specify)	moval from State 20b. Place ceme	0500 RO of Disposition of the properties of the	(Name of or other plac	9)	Date	20c. Location - C	S. MD 20852 City or Town, State LES, CALIFORNIA
Balti	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service License		DANZ	ne and Addres	s of Facility GOLDBERG	MEMORIA	AL CHAPEL	S, INC.
	Physician /Medical Examiner	:	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause on end fine PC LS Due to (or as a consequence)	ce of):	mode of dyin	g, such as cardiac	or respiratory a	ON/	Approximate Interval Between Operat and Death
30,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence LENA U	一干	ALLU	RE E2			Years
.O. Box 68760,	law requires that the death certificate be as been signed by the attending physici: 2 should be detached for use as the bu	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 ⊟Ecto	pic pregnancy or (specify)			23d. Date Mont	of delivery h Day Year
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Division of Vita	Attending Physicien: The death. ector: Atter this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home	b. Time of Injury M		4 🗆 Nursing n	ome 5 Resi	idence 6 Other	1
Ď	Hospitel or 124 hours after Funerel Dire tely filled in the control of the contro		29a. Certifier 1X Certifying Phys	building, etc. (Specity) cian: To the best of my knowled	dge, death occu	urred at the tin	ne, date and place	, and due to the	wn, State) cause(s) and man	ner as stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ft	Medical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	and/or investig	ation, in my o	pinion, death occu	rred at the time,	date and place, ar	(Month, Day, Year)
	16		39. Name and address of person who con	npleted cause of death (Item 23	(Type, Print)	J 42	2/60		4/21/	05
	Sta	to	PCTR HAUSUER 31. Date filed (Month, Day, Year)	MD PbD 8600 32. Registrar's Signature	000	GEOR	6ETOW/	V 30,	BETHESI	DA, MD, 20814
	Regist		APR 2 6 20	15 Brew &	Monde	a. Je		,		

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Registrar

			For State	State of M		epartment of F Certificate of			6000	15797
			Registrar 1. Decedent's Name (First, Middle	l ast)		Certificate of	Dealii	2. Date of Death	. No.	3. Time of Death
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	/Medic		4a. Facility Name (If not institution,				r Location of Death	April 2	4c. County of Dear	
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	Funeral		5. Social Security Number	11 - 1 - 0	ge (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
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	pu ,		Usual Residence of Decedent		140.00 =		<u> </u>			
	shov	'n	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	with a or	Ω	10e. Street and Number	7d 7 -		10f. Zip Code	1=0	109	. Citizen of What Co	ountry?
	eath	era	300 St. Luke C	12. Was Deceden	t Ever in U.S.	13. Was Decedent of H	.158	acity Vas or No-	USA 14. Race - Ame	rican Indian
	fter d	by Funeral Director	1 Never Married 2 Marri	Armed Forces	?	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
8	urs a	by	3 ¼Widowed 4 □ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Exam or mast be molified at	Completed	15. Decedent (Specify only highes		16a.	Decedent's Usual Occup (Give kind of work done)	ation	16	b. Kind of Business/	Industry
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-40)	5+)	life. DO NOT use retired	d)		Cosmetolo	wi 7
	ygier ygier nar th	Cor	8			Beauticia				3Y
<u>n</u>	be fill htal H hd oth	Be	17. Father's Name (First, Middle, I	,				First, Middle, Ma.	iden Sumame)	
$\frac{8}{5}$	rould I Mer narke	은	Franklin H. T				Emma He			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other traumatic avent, the Medical Exam and must be notified at once.		19a. Informant's Name/Relationsh Janet Falkensti	1 1 27		Mailing Address (Street . O Bankard R		al Route Number, C minster,	-	
	1 and Healt am 2		20a. Method of Disposition			Disposition (Name of y, crematory or other place			c. Location - City or	
Baltimore,	ages int of t: If it		1√2 Burial 2 ☐ Cremation		9 .		I			
Ħ	nit. Partme artme ortan injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Druta	Ridge Ceme			Baltimore,	
B	permi Depa Impo any ir		1/1/	-/-		Pritts Fu	neral Hom	e and Cha	pel, P.A.	21157
			23a. Part1. Enter the disease, or	complications that cause	ed the death. Do n	412 Washii ot enter the mode of dyin	ngton Road ig, such as cardiac c	d Westmi or respiratory arrest	nster, M	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	101	2004			Interval Between Onset and Death
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ľ	Examiner					,				
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	Due to (or a	s a consequence o	of):				
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
Ö,	e exe ian a urial-	Ē	resulting in death) Last	Due to (or a	s a consequence o	f):				
68760,	ate b	edical		d						
_			IF FEMALE:	220 If you system						
Вох	eath certif attending for use a	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pregnancy	,		23d. Date of deli Month	v <i>er</i> y Day Year
<u>Р</u> О	the de	Physician/M	1 □ Yes 2 ŪNo 9 □ Unknown	9□ Unknown	at time of death	5 Other (specify)				
	Attanding Physician: The taw requires that the death certif rdeath. rdeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Ph	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Sp	uires sign ld be	d by						1 ☐ Yes	200 3 Pro	obably 4 Unknown
Records,	w requir s been si should	Completed						24a. Was an	24b. Were au	topsy findings available
Be	The tavate has	dmo				· · · · · · · · · · · · · · · · · · ·		autopsy performed	prior to death?	completion of cause of
Vital	ician: Th	a)	25. Was case referred to medical	1			26. Place of Death	1 Yes 2	No 1 ⊔Yes	2□ No
\leq	ysician: is certific director,	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 ER/Out	patient 3 DOA Othe	er:		e 6 Other (Spec	ify)
0	ding Ph h. After th funeral	n: T	27. Mann of Death	28a. Date of Inj (Month, D	ury 28b. T	me of 28c. Injury		28d. Describe how i		,,
0	andir.	atlo	1 atural 5 Pending 2 Accident investig	ation	., , , , , , , , , , , , , , , , , , ,		Yes 2 □No			
Division of	F 9 F C	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 288. Place of it	njury - At home, far	m, street, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Ru State)	ra / Route Number,
	urs af									
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the basis	ot examination and	death occurred at the time	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	tha thin 2 tha mplel	Med	29b. Signature and title of certifier	and manner s	tated.	29c, License			Date signed (Month	
1				pin (gra	2PMD		359943		pal 25,	
	MIL		30. Name and address of person v					/ / /	F 2/	
	7		John C. A.			rype, Print)	2 367	mestu	inster "	10 2(157
ستنيف	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature			V - 1		2(3)
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Physici	an	1. Decedent's Name (First, Middle, Last)	ia .						2. Date of Deat	Pay 22	Year_	3. Time of I	
/Medic	cal	Pobert Bye		<u> </u>	45 05. 7		Location of	(D 1)	АРГІІ		2005	8:30P	М
Examin	ıer	4a. Facility Name (If not institution, give s 1535 Miller Rd.	treet and number)				minst				unty of Death		
Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday,	If Under		If Under 2 Hours		8. Date of Birth		9. Birtho	lace (State or	r Foreign
Director		Usual Residence of Decedent	M 2 F	65 Yrs.		Days	Hours	IVIII1.	July 12	,1939	Mar	yland	
e Marylar e-f show	ctor	Maryland Carrol		10c. City, Town or L		tmin	ster				1	0d. Inside Cit	
vith the	Dire	10e. Street and Number			10f. Zip	Code	01150		1	0g. Citizer	of What Cour	•	
eath v	erai	1535 Miller Rd.	2. Was Decedent Ev	er in U.S. 13.	Was Deced	ent of Hi	21158		cify Yes or No-	14.	U.S.A		
parifilliore, Intal yialing Z.I.Z.I.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural, or items 23e or 28e-f show any injury or other traumatic svent. The Neulaul Exam metrical to other traumatic svent. The Neulaul Exam metrical to other traumatic svent.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:1		If Yes, speci		Specify:	Puerto F	cify Yes or No- Rican, etc.)		Black, White,	etc.	
A I X I 3-0030 ad within 72 hours aff giene. er than "netural", or the Medical Exam.	pieted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usua kind of won DO NOT us	l Occupa k done o e retired,	ation luring most	of workir	ng	16b. Kind	of Business/Ind	dustry	
filed with Hygiene. other than	Con	Elementary/Secondary (0-12)			re	alto					estate	sales	
INICITYICIUM d 2 should be file tith and Mental Hy 77 Is marked oth traumatic svent	To Be	17. Father's Name (First, Middle, Last) Norman T. Morri	5						(First, Middle, Maret Ma				
VICII 12 shc h and 7 Is m raum		19a. Informant's Name/Relationship (Type Sue Ann Morris/ w	. ,		ng Address Mille				Route Number			Code)	
e, IV 1 and Health Health shertr		20a. Method of Disposition		20b. Place of Disposemetery, cre					minster ate	•	ion - City or To	wn, State	
Pages Pages nent of I		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	J.L. Mill	matory or ot er Mer	h <i>er placi</i> n . C	em. 4	/30/			•		
DAILIMOTE, permit. Pages 1 at Department of Hea Importent: If item any injury or othe		21. Signature of Funeral Service License	. Warte		2. Name and	d Addres	s of Facility	Har	tzler F w Winds	unera	1 Home		
Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	John m				cardiac o	r respiratory arre	est,		Approximate Interval Betw Onset and D	veen
ob/ boy, ifficate be executed x g physician and as the burial-transit unial-transit as the burial-transit as t	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):									
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w requires that been signed to should be detailed.	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	underlying ca	iuse give	en in Part I.		23e. Did tob	1000	contribute to the	ie cause of de ably 4 ⊟Ui	
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OI VICAL Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	ospital:			Otho		of Death	(Check only on	e)			
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To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory,	, office		2	8f. Location (St. City or Town		umber or Rura	l Route Numb	per,
To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I	Medical C		icien: To the best of ler: On the basis of e and manner state	xamination and/or in									
To the To the Comp	Me	29b. Signature and title of certifier					number		2	9d. Date s	igned (Month.	Day, Year)	
MSL		> Hyspolin	m		1	>33	501			4/2	5)05		
W 10		30. Name and address of person who co Stephen J. Sikor			Print) ashing	ton	Rd.	We	stminste	er, M	D 21157		
Sta Registi		31. Date filed (Month, Day, Year) APR 2 6 7	32. Registrar		Such	,							

DHMH 17 Rev 1/2001

ROBERT EUGENE MORRIS

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** 11:00 PM lloma a 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Medical Center SelAir Harford Upper (he 5. Social Security Number Chesa Peake If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Mpnth, Day, Year) Birthplace (State or Foreign Country) Funeral Hours July 8, 1927 1□ M 2 F Vrs 218341860 YOME Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Jarrettsville Director Harfor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21084 USA or Items 23a arrettsville Rd 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Im 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Almena Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is u Jarretsville MD 21084 Jarrettsville Rd Malea 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place; 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 6, 2005 FD \$1355/1-2 22. Name and Address of 4 Donation 5 ☐ Other (Specify) 21. Signature of Fytheral Service Ligense 22. Name and Address of Facility 902 MT Rose Ave Keffer Funeval Home Inc York, PA17403 23a. Part1. Enter the disease, or complications that a user the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) + INTRA VENTRICULAR HEMORRHAGE SUB ARACHINOID 8 Days **Physician** /Medical Due to (or as a consequence of): Examiner CEREBRAL ROPTURE D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ALOMA 1 Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown HUPERTENSION Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 ☐ Yes 2 3 NO 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

00

State Registrar

31. Date filed (A)

FRANZ

C.

VELLA-CAMILLERI M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

D021207

2005

5 MIDCREST CT., BACTHORE, MD 21286

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician JAMES** NEWSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 9. Birthplace (State or Foreign) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs 70 Brooklyn, NY Director 072-26-2857 February 28 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other than "neturel", or flems 23s or ?se. -- any injury or other traumatic event. 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1√2 Yes 2 □ No Hyattsville Directo Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 6804 Webster Street Funeral 12. Was Decedent Ever in U.S.
Amed Forces?

1 X Yes 2 No Airforce
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: ρ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Crane Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eva Todd Gus Newson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 344 Orange Blossom Trail Roanoke Rapids N.C. 27870 Iris Newson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 4/28/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Ves 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Hospital: Other: 2 EP/Outpatient 3 DOA ۵ 1 🗌 Yes 1 🔲 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) His 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 - Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and the of certifier H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEENSBURY RD ne 4404 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 7 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan		artment <i>rtificate</i>			ind Me	ental Hygid Reg	ene	005	15802
	Physici	an	1. Decedent's Name (First, Middle, Last)							2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	EMILY CLAIRE NOCK 4a. Facility Name (If not institution, give s				45 Oit 7			10	APRIL 3			12:20A M
	Examin	er	3551 SWANTON ROAD	street and numb	er)		4b. City, T	SWANT		T Death		4c. Co	unty of Deat	
	Funeral		Social Security Number 6. Sex		Age (In yrs.	last birthday)	If Under 1	Year II	f Under 2		B. Date of Birth	()	9. Birt	hplace (State or Foreign
	Director		244 02-3103	M 2∭ F	63	Yrs.	Months	Days	Hours	Min.	Month, Day, 1 1AY 5, 1	941_		NC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary f sho	tor	MD GARRETT			SWAN'	TON							1∑Yes 2□No
	or 28e	Director	10e. Street and Number			DWIII	10f. Zip (Code			100	g. Citizer	of What Co	untry?
	23e c	ral D	3551 SWANTON ROAD				2	21561				USA	Δ	
	er dez	nue		12. Was Decede Armed Force	es?	.S. 13. \	Vas Decede f Yes, specif	nt of Hispa fy Cuban, I	anic Orig Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14.	Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. than "naturel", or tems 23e or 28e-f show the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	∑ No ≤	Specify:			Sp	ecity: W	THITE
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Maryland 21215-0036	d la l	Be c	17. Father's Name (First, Middle, Last) STILLMAN		LEA	RV		18	DEL	·	First, Middle, Ma			NT)
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ore	of He		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐R	emoval from Sta		Place of Dispo emetery, cren	sition (Name	e of ner place)		Dat	te 20	c. Locat	ion - City or	Town, State
altimore,	Pages treet of I tent: If it jury or o		'4 □ Donation 5 □ Other (Specify)			MEGA CI	REMATO	RY	5	/2/05		MORG	ANTOW	N, WV
Ba	permit. Pages Department of I Importent: If its any injury or o		21. Signature of Funeral Service License	90	W001		. Name and				P.O.			
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	Physician		shock, or heart failure. List only on Immediate Cause (Final											Interval Between Onset and Death
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	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
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8760,	icate be executed physician and s the burial-transit	dical E												
9	rtifical	Medi	IF FEMALE:											
Division of Vital Records, P.O. Box	The law requires that the death certificate has been signed by the attending is age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom 1□Live birth	2 Feta	Ideath 3□	Ectopic pre					23d	. Date of deli Month	very Day Year
O	he de	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnan 9□Unknow		eath 5□	Other (spec	cify)					W.G. III	ou, vou
ټ.	res that t signed by I be detac	by Ph	Part II. Other significant conditions con	tributing to deat	h but not res	ulting in the ur	nderlying cau	use given i	n Part I.		23e. Did toba	cco use	contribute to	the cause of death?
rds	quires in sign	q pa									1 □ Yes	2 ∑ N	lo 3□Pro	obably 4 Unknown
ဝ္ပ	e law requir has been s ge 2 should	plet									24a. Was an	2	4b. Were au	topsy findings available completion of cause of
ř	10	Completed									autopsy performe 1 Yes 2∑	ed?	death?	2□ No
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case reterred to medical examiner?						6. Place	of Death (Check only one)			
ō	Physic this crail dire	2	1 ☐ Yes 2 ☐ÑNo ☐ ☐	ospital: 1 ☐ Inp. 28a. Date of I		ER/Outpatien 28b. Time of					d. Describe how			ify)
o	Jing After	tlon	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month,	Day Year)	Injury	м 20	c. Injury at Work? 1 ☐ Yes	2 □ N		d. Describe now	піцшіў Ос	COLLEG	
N N	= 0 5	ifica	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho	ome, tarm, stre	et, factory,	office		28			umber or Ru	ral Route Number,
	tel or rs afte el Dir ed in	Certification:	4 Normade	bullding,	etc. (Specify	r) 					City or Town,	31a16)		
	To the Hospitel or A within 24 hours after to the Funerel Direction Completely filled in by	Medical	29a. Certifier (Check only one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check one) **To Certifying Physical Examination (Check on	ician: To the be ner: On the basi and manner	s of examina	wledge, death tion and/or inv	occurred at restigation, in	the time, n my opinio	date and on, death	place, and occurred	d due to the cau at the time, date	se(s) and and pla	d manner as ice, and due	stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1/1	2		29c.	License nu	umber		290	I. Date si	gned (Month	, Day, Year)
			1 and to	nus	90			3003	35		C)5/0	1/200	05
			30. Name and address of person who co Donald R. Rich	mpleted cause of	of death (Item	123a) (Type, 1 1533 1	Print) Memor	ial	Dri	ve C	akland	d, M	ID 215	550
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signa		Great	R						

			1- For State of Maryland / D	Departme Certifica			nd Me		giene ()	05	15803
Н	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	ROBERT LEE OTTEY 4a. Facility Name (If not institution, give street and number)	4h Ci	ity Town or	Location of		APRIL		2005 nty of Death	11:51P M
	Examir	ier	13630 PADGETT COURT			TTE H				ARLES	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		der 1 Year	If Under 24		B. Date of Birth			place (State or Foreign
	Director		578-14-4619	Yrs.	July s	110013	1	B. Date of Birtl (Month, Day MAY 17	, 1926	WEST	VIRGINIA
	/land		10a. State 10b. County 10c. City, Town	n or Location						1	Od. Inside City Limits
	a-f sh	ctor	MD CHARLES CHARL	OTTE HA	ALL						1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f.	Zip Code				10g. Citizen	of What Cour	ntry?
	eath v	eral	13630 PADGETT COURT 11. Marital Status 12. Was Decedent Ever in U.S.	12 Was Do	20622		-2/5	t. V N.		S. A.	1-11-
0	hours atter death with the Maryland lurel', or Items 23a or 28a-f ehow Examiner must be notified at	Funeral	Armed Forces?		***		Puerto Ri	fy Yes or No- can, etc.)	14. H	lace - Americ lack, White,	
ğ	ours a	d by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: W.W.II	1 ☐ Yes	2 2 No	Specify:			Spe	cify: WHI	TE
5	n 72 h "netu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's U (Give kind of life. DO NOT	sual Occupa work done d	ation furing most o	of working	,	16b. Kind of	Business/In	dustry
77	l within 72 iene. r than "nel	omp	Elementary/Secondary (0-12) College (1-4or 5+)	PE FIT)			STEAM	ያዝጥጥፑጽ	S UNION
פ	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "neturel", or Items 23a or 28a-f show event, It a Madical Examination and be notified at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle,			BUNION
ylaı	should be filed nd Mental Hygi s marked other umatic event, II	To	WILLIAM R. OTTEY			GLEMA	LYNN	MADDY	ζ		
Maryland 21215-0036	is a is			. Mailing Addre							
<u>ი</u>	tem 27		20a. Method of Disposition 20b. Place of	630 PAI Disposition (A	Vame of		CHAF PRIL		HALL,		
altimore,			XXBurial 2 Cremation 3 Removal from State	ry, crematory`o Y MEM .			5, 20		VALDOR1		
<u>=</u>	permit. Page Department Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	22. Name		1	-			-	.HME.,P.A.
	20529		found but be M00641	30173						HALL,	MD 20622
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final		4 .			espiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of		47	CER					
ı.	Examiner			,-							
	sit ad	ılner	Sequentially list conditions, if any leading to firm ediate cause. Enter Underlying Cause (Disease or injury	00)1							
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of	of):						-	
8760	ate be executed hysician and the burial-transit	dical E	d	,							
9	ntifica ing ph		IF FEMALE:								
ROX	death certific e attending p id for use as i	hysiclan/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death							Date of delive Month	ry Day Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other	(ѕреспу)						
ທົ	requires that the neen signed by th hould be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in	the underlying	g cause give	n in Part I.		23e. Did to	bacco use co	ntribute to th	e cause of death?
g	w require been sig						_	1 🗆 Y	es 2 🗆 No	35 Prob	ably 4 Unknown
හ ග	aw Is b	ompleted						24a. Was a autops	sy	prior to con	osy findings available inpletion of cause of
ā	Thate page	0	Of Was and referred to medical					perform 1 ☐ Yes	211 No	death?	2 No
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ N Hospital: 1 ☐ Inpatient 2 ☐ EP/Out	tpatient 3 [Check only on		ther (Consid	
	ding Phys h. After this funeral di	Ju: T	27. Magner of Death 28a. Date of Injury 28b. T		28c. Injury Work	at ?		d. Describe h			,
<u>0</u>	r Attending er death. rector: After by the fune	catle	2 Accident investigation	М	1 🗆 Y	′es 2□No					
Division	i i ite	ertification;	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, facto	ory, office		28f	Location (SI City or Town	treet and Nun n, State)	nber or Rura.	Route Number,
_	ospitel hours a unerel (y filled	O	29a. Certifier 12 Certifying Physician: To the best of my knowledge,	, death occurre	ed at the time	e, date and p	place, and	d due to the c	ause(s) and r	nanner as st	ated.
	To the Hos within 24 h To the Fur completely	ledical	one) Medical Examiner: On the basis of examination and and manner stated.	d/or investigation	on, in my op	inion, death	occurred	at the time, d	ate and place	and due to	the cause(s)
	vit Con	Σ	29b. Signature and title of certifier	2	9c. License	number		2	9d. Date sigr		
			30. Name and address of person who completed cause of death (Item 23a) (Type Print)	0 1	- 5) ~		APRIL	22, 2	2005
h	B1081		KRISHAN MATHUR, M.D. 3500 OLD WAS		N ROAI	D #102	WAL	DORF. 1	MARYLA	ND 206	02
	Sta		31. Date filed (Month, Day, Year) 32. P gistrar's Signature					,			
	Registr	ar	APR 2 5 2005 Keeper 15	1							

J			1 - State Unpe	end Item	State of M 23a&27 pe	larylan r me	d/Deni G843	artment	of He	ealth ai	nd Me	ental Hy	giene	2005		1580	Lz
			Decedent's Name									2. Date of Dea	ath		Т	3. Time of Death	1
	Physici /Medic		Ma	rgaret	Carroll	Pu	rnell					Month	Day			٥٥ - ٦٥	М
	Examin		4a. Facility Name (II	f not institution, give	street and number,)		4b. City, T	own, or I	Location of	Death	April .	30 _{24c.}	2005 County of Dea	ath)2:55 p .	•
0					ospital C	enter			ever				Pr	ince G	eor	ge's	
0	Funeral		5. Social Security N		9x 7. A	-	ast birthday)		Year Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birt (Month, Da	th y, Year)	9. Bi	rthplac	e (State or Fore	ign
3	Director		577-68-0	1229		55	Yrs.					June 25,			C.		
	land		10a. State	10b. County		10c. City	, Town or Lo	ocation							10d	Inside City Limi	its
	Many f sh	ğ	MD	Prince Geor	rge's		Lanham									1 N Yes 2 □ N	No
	r 28e	rec	10e. Street and Nur	nber				10f. Zip (Code				10g. Cit	izen of What C	ountry	?	
	h with	<u>e</u>	10204 Ex	erley Terra	ace				20706	5			τ	J.S.			
	ems ems	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces	t Ever in U.	S. 13,	Was Decede	ent of His	spanic Origi	n? (Spec	ity Yes or No-	-	14. Race - Am Black, Whi			
36	or it	y Fu		ed 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No		1 Yes 2		Specify:		10411, 010.)		Specify: BL		•	
5-0036	hour:	d by	3 Widowed		Year or Dates:		10. 5		_								
5	n 72 "nel	lete		15. Decedent's Ed ify only highest gra			(Give	dent's Usual kind of work DO NOT use	done du	urina most d	of working	7	16b. K	ind of Business	s/Indus	itry	
2121	withi iene. then	Completed	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		ative Se	,				Pos	tal Serv	iœ		
Ď	filled I Hyg other	Be C	17. Father's Name	(First, Middle, Last)						18. Mother	s Name (First, Middle,	Maiden	Sumame)			
a	Ald be Alenta rked tic ev	To B	Theodore	Carroll						Marga	aret W	lillia	ms				
Maryland	short short			ame/Relationship (7										r Town, State,		ode)	
_ ≥	and 2 ealth n 27 ler tre		Bernard	I. Purnel	.1, JrSp	ouse	102	04 Eve	rley	Terr	ace,	Lanha	m, M	1D 2070	6		
ore	of Hi of Hi if iter		20a. Method of Disp		Removal from State	_ 00	emetery, cre	osition (Name matory or oth	ner place		Da	te	20c. Lo	ocation - City o	r Town	, State	
Ë	Pag ment tent:			5 ☐ Other (Specify		Ft		ln Cene			-6-05			ntwood, M			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinational be motified at Once.		21. Signature of Fu	neral Service Licen	E Col	(lie)		2. Name and 2504 28					S30C.	, Funeral	. Ha	me	
	3		23a. Part 1, Enfer the shock, or hea	he disease, or comp rt failure. List only	olications that cause one cause on each	d the death	. Do not en	ter the mode	of dying	, such as ca	ardiac or	respiratory ar	rest,		A	oproximate terval Between	
	Physician	Ų, į	Immediate Cause ((Final	Hyperte		Cardi	iovasci	ular	Dise	ase				0	nset and Death	
	/Medical Examiner		resulting in death)		Due to (or as												
	Examine	_	Sequentially list co	nditions,	b												
	pe isi	Examiner	Sequentially list con ir any, leading to in cause. Enter Unde Cause (Disease or	injury	Due to (or as	s a consequ	ionee ory:										
	xecul and al-trar	хап	that initiated events resulting in death) I		c. Due to (or as	s a consequ	uence of):								-		
8760,	cate be executed oblysician and the burial-transit			l													
687	ificate g phy as the	edlo			. d												
Вох	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			7= . 7 .						23d. Date of de	elivery		
	death e atte	icla	in the past 12 1 Yes 2		1□Live birth 4□Pregnant a			□Ectopic pre □ Other (spe						Month	Da	y Year	
P.O.	at the by th tache	hys	9 🗌 Unknown		9□ Unknown												
	The law requires that the death certific that been signed by the attending p. tee as should be detached for use as	by F	Part II. Other signif	icant conditions o	ontributing to death	but not resu	alting in the u	inderlying car	use giver	n in Part I.		23e. Did to	obacco u	use contribute t	to the	cause of death?	
Vital Records,	pinoi pinoi	ted										101	/es 2	□No 3□P	robab	y 4 Unknow	NΠ _
ec	law ras be	Completed								_	_	24a. Was		24b. Were a	utopsy	findings availab	ole of
A.	slcien: The lar certificate has rector, page 2	Con										perfo	rmed? 2 □ No	death?		□ No	
# Sign	cien: ertific	Be	25. Was case refer examiner?	red to medical	Haia-li							Check only o					
P	Phys this at dir	2	1 X Yes 2 ☐ 27. Manner of Deat		Hospital: 1 Inpat			nt 3 DOA	Omei	r: 4 🗆 Nurs		e 5 🗆 Resid		Y Other (Spe	ecify)	Scene	
u	ding F h. After funera	lon	1 X Natural	5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	M 28	c. Injury Work	at ? ′es 2.∐N		ld. Describe h	10W Injur	y occurred			
Division	f or Attendi after death. Director: A I in by the fu	lical	2 Accident 3 Suicide	investigation		niury - At ho	me farm st			93 2 14		of Location (5	Street an	d Number or R	Rural F	oute Number	
Div	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 Homicide	determined		etc. (Specify		root, tuotory,	OIIIOO			City or Tox			iurui ri	outo rvambor,	
	hours inerei		29a. Certifier	1☐ Certifying Ph	ysicien: To the bes	t of my kno	wledge, deat	h occurred a	t the time	e, date and	place, an	d due to the	cause(s)	and manner a	s state	ed.	
	he Ho n 24 he Fu	Medical	(Check only one)	2 XMedical Exam	niner: On the basis of and manner s	of examinat	tion and/or in	vestigation, i	in my opi	inion, death	occurred	at the time,	date and	d place, and du	e to th	e cause(s)	
	To t To t	Σ	29b. Signature and	title of certifier		11.		29c.	License	number			29d. Da1	te signed (Mon	th, Da	y, Year)	
) (e	ulivill	108 1	g4.			OCI	ME			Ma	y 1, 20	005		
0	(3)		30. Name and addr	ess of person who	completed cause of	death (Item	23a) (Type,										
1			31. Date filed (Mon	th Day Your	P O Paris	Ly Size	turo	111 H	enn	Stree	e t E	Baltimo	ore,	Maryla	nd.	21201	
	Sta Registi		MA'	y 0 5 2005		trar's Signa	ture-	L									

DHMH 17 Rev 1/2001

		1 - State of M	aryland / Depa	artment of H			giene ()	05 1580	5
Physic		Decedent's Name (First, Middle, Last) LORRAINE V		RACKHAM		2. Date of Dea Month	Day 25, 200	Year 05 9:15 A	
/Medi Examir		4a. Facility Name (If not institution, give street and number,)	4b. City, Town, or	Location of Death	April		y of Death	
		Somerford Assisted Living		Freder				lerick	
Funeral Director		5. Social Security Number 6. Sex 7. As 1 M 2 F	ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day DEC. 16	(, Year)	9. Birthplace (State or Forei Country) Utah	<i>ig</i> n
and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City Limi	its
death with the Maryland ms 23a or 28a-f show frtust to notified at	to	Virginia Fairfax	Reston					1 ☐ Yes 2 € N	
h the rr 28a	Director	10e. Street and Number	.1	10f. Zip Code		1	10g. Citizen of	What Country?	
23a c	raiD	11006 Burywood Lane		20194		Ţ	United	States	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at any injury or other treumatic event, the Madical Examiner must be notified at any lauge.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces* 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	1	ce - American Indian, ack, White, etc. ^{fy:} White	
be filed within 72 hours after tall hygiene. Id other than "natural; or its event, the Modical Examina	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worl)	king		Business/Industry	
A with	Con	4		lomemaker				home	
Id be file fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Edward	Vernon		18. Mother's Nam Eva	ne (First, Middle, i Blar	<i>Maiden Sumai</i> nche	_{тө)} Bowen	
2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number	r, City or Town	, State, Zip Code)	
and and man an		John Scott Rackham / son		6 Burywoo	od Lane/				
Pages 1 nent of H int; if ite		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □Removal from State		matory or other plac				- City or Town, State	
Default. Pages Department of Mportant; If It any Injury or o		* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Frederick		- 1			ick, Maryland Homes, P.A.	_
permit. Departr Importa any inje		Boumond eler		621 Oposs					
Physician /Medical Examiner buysician and physician and physician and street buying the private of the physician and physician a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Desact of thin) that initiated events c.	a consequence of): a consequence of): a consequence of):		eno mo		est,	Approximate Interval Between Onset and Death 2 mo n4V	
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		2 Fetal death 3	Ectopic pregnancy				ate of delivery onth Day Year	
w requires the been signed should be de	by	Part II. Other significant conditions contributing to death I	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		atribute to the cause of death? 3 Probably 4 Unknow	٧n
vical necovicion: The law recentificate has be	Completed					24a. Was a autops perform	sy med3	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	ole if
Physician: 1 This certifical	Be	25. Was case referred to medical examiner?		othe Othe	26. Place of Dea	th (Check only on	18)	Assisted	
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2	ation: To	1 Yes 2 No 103/1011 1 Inpati 27. Manner of Death 1 Natural 5 Pending (Month, Diagram) 2 Accident investigation	ury 28b. Time of	f 28c. Injury Work	at	ome 5 ☐ Reside 28d. Describe ho		Assisted her specify Living rred	
or Attending after death. I Director: After din by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Numi n, State)	ber or Rural Route Number,	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical C	29a. Certifier Certifying Physician: To the best (Check only one) Amedical Examiner: On the basis and manner st	of examination and/or in	n occurred at the tim vestigation, in my op	e, date and place, binion, death occur	and due to the cared at the time, d	ause(s) and malate and place,	anner as stated. and due to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	۸	29c. License	number	2	29d. Date signe	ed (Month, Day, Year)	
1			Hren, mi		51643	3	11257	05	
~/		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Deies)	Freden	-1-	200	21700	
Sta Regist	ate rar		rar's Signature	Sant,	ri (Igh	015	V. V. C	470	

			State of State of State of Registrar	Maryland / Department G843	artment of H	lealth an	d Mental Hyg	iene 005	15806
			Decedent's Name (First, Middle, Last)		inoato or i	Doutin	2. Date of Dea	3	3. Time of Death
	Physici		Paul Joseph Riessler				April	25, 2005	
	/Medio Examir		4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or	r Location of D		4c. County of Dea	9:50 A M
1	Admii		Gilchrest Hospice Hou		Towson			Balti	
	Funeral		5, Social Security Number 6, Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	0.0	
ш	Director		217-00-3124 18 18 2□ F	49 Yrs.	Months Days	Hours I	Min. Dec. 9,	1955 Mai	thplace (State or Foreign buntry) Cyland
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					
	shor	'n	,						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Directo	Maryland Baltimore 10e. Street and Number	Balt	imore				
	with with	ā			10f. Zip Code			0g. Citizen of What Co	,
	eath	by Funeral	351 Oberle Avenue 11. Marital Status 12. Was Dece	dent Ever in U.S. 13.	21221			United S	
'	fter d	Fun	Armed For	ces?	If Yes, specify Cuba	in, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
036	urs a al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv.		1 ☐ Yes 2XX No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Examinar must be notified at	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	. , .	16b. Kind of Business	Industry
2	within and the within and the wed	npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+)	kind of work done of DO NOT use retired	puring most of Progr	'ammer		
	ed wi	Cou	3	Comp	uter Ana	inlyst	;/	Technolo	ogy
lud	d oth	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle, I		
<u>y</u>	ould Men Marke	To	Erich Herman Riessle					ette Pie	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Examinar must be notified at	0 8	19a. Informant's Name/Relationship (Type, Print) Linda Riessler / Wife	19b. Mailir 351 (ng Address (Street a	and Number o	r Rural Route Number	, City or Town, State, 2	Zip Code)
	permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra once.		20a. Method of Disposition	20b. Place of Dispo					
Baltimore,	ages nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Removal from S	State cemetery, crer	natory or other place		orii 21,	20c. Location - City or	Maryland
Ħ	artme artme ortani injuri	. 1	*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Communications	Holly Hi				iddle Riv	er,
Ba	permit. Departr importu any inji		1111	R	esthaver 501 Cato	î Fûne:	ral Servi	ces, Skko	ot Cody P.A ck, MD 2170
			23a. Part1. Inter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not ent	er the mode of dying	g, such as can	diac or respiratory arre	est.	Approximate
	Physician		Immediate Cause (Final				Ceuken		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Pronte L	7 000 000	67116	CEOKE	m , 9	Jeon
	Examiner								U
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of):				-	
	cuted nd ransi	Examiner	that initiated events						
0,	e exe ian a urial-1	Ĕ	resulting in death) Last Due to (d	or as a consequence of):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d						
9	eath certific attending p	Mec	IF FEMALE:						
Box	ath co	lan/	200. Was decedent pregnant		Ectopic pregnancy			23d. Date of del Month	1
0.	the a	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			MONTH	Day Year
Δ.	that the deed by the detached		Part II. Other significant conditions contributing to de	ath but not resulting in the u	ndorhina oausa awa	on in Bod I	220 Did toh	pacco use contribute to	the course of death?
Records,	ires that signed t d be deta	d by	Tarris of the original contributing to de	attrout not resulting in the di	ndenying cause give	en in Pait I.	239. Did (00	1	
Ö	w require been sig should t	etec					_	3 2 2 10 3 1 7	obably 4 Unknown
3ec	has l	Completed					24a. Was ar autops	y prior to d	topsy findings available completion of cause of
a							perform 1 Yes 2	ned? death? 1 ☐ Yes	2 □ No
Vital		Be	25. Was case referred to medical examiner?		t 3DDOA Othe	20	Death (Check only on		1/
of		5 7	1 ☐ Yes 2 ☐ No 1 ☐ Ir 27. Manner of Death 28a. Date o	patient 2 ☐ ER/Outpatien Injury 28b. Time of	, oll box	- I I I I I I I I I I I I I I I I I I I	g Home 5 ☐ Reside		city) Hospice
OU	iding Phy th. : After this funeral c	tion		, Day Year) Injury	Work	rat (? Yes 2 □ No	28d. Describe no	w injury occurred	
Division	Attendir death.	fica	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, str			28f. Location (Str	reet and Number or Ru	ral Boute Number
Ö	s after	Certification:	4 Homicide determined buildin	g, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	, State)	
	pspltu hours unera y fille		29a. Certifier 1 Certifying Physician: To the	pest of my knowledge, death	occurred at the tim	ne, date and pl	ace, and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one) 2 Medical Examiner: On the ba	sis of examination and/or inv er stated.	estigation, in my op	oinion, death o	ccurred at the time, da	ate and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0	29c. License	number	29	d. Date signed (Month	n, Day, Year)
	_		1 th they le	an h	1)2	(205	14	pri (25.	2005
	3		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	0 0	Ct o	22 11 7	,211
			W. Id . Kiley 6	5mc 670	11.00	reres	Sti toa	100 md C	1 - 0 &
	Sta Registr	te ar	30. Name and address of person who completed cause 31. Date filed (Month, Day Year) 32. R	ustrar's Signature	good o				

HORL 25,2005 OAHO RESSIEN POUL

			riease	State of M					•	_	lible.	
			For State	State of M	arylan		tificate of	lealth and M		E. U	105	15807
	1 2	-	Registrar 1. Decedent's Name (First, Middle, La	a sél		Cei	uncate of	Dealli	2. Date of De.	Reg. No.		2. Time of Death
	Physicia	an		•	ъ.				Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gi	rie		chardso		r Location of Death	April		005 ty of Death	12:00PM
	Examin	er	Wicomico Nur				Salis				comica	
	Funeral					last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			ce (State or Foreign
- 1	Director		220-80-2797	1□M 2XF	90	Yrs.	Months Days	Hours Min.	2/12/19	y, Yea <i>r)</i> 915	Mary	
	PL ,		Usual Residence of Decedent		10.00							
	anyia shov	-	10a. State 10b. County			y, Town or Lo					100	Inside City Limits 1X Yes 2 □ No
	Se-f	ecto	Maryland Wicom	100	5	Salisbu						
	death with the Maryland ms 23e or 28e-f show in ust be notified at	Funeral Director	10e. Street and Number 100 Pacific Ave				10f. Zip Code			10g. Citizen of	What Country	y?
	eath	eral	11. Marital Status	12. Was Decedent	Ever in II	S 13 1	2180		cify Yes or No	USA 14 Ra	ıce - American	Indian
(0	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀				lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	BI	ack, White, etc	c.
360	urs a	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes 2⊠ No	Specify:		Spec	^{ify:} whi	te
6 5	72 ho natur	Completed	15. Decedent's E (Specify only highest gi	Education		16a. Dece	lent's Usual Occup	pation		16b. Kind of I	Business/Indu	stry
21	ithin Mer	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of worki d)	'y	_		
1/2	led w lygier her th	S	12			Homem	aker			Domes		
27 00	tal Find of ot	Be	17. Father's Name (First, Middle, Las Pete Miciotto	t)				18. Mother's Name				
2 2	hould d Me nark natio	잍	19a. Informant's Name/Relationship	(Type Brint)		10b Mailie	a Addraga /Stroat	Josephir and Number or Rura		(unknow	=-/	o de l
Richard Star	d 2 s th an t7 is trau		Dolores Ann McI		n hter							000)
3 0	Heal Heal		20a. Method of Disposition	rear 117 add	20b. P	lace of Dispo	sition (Name of	Ave., Sal	ate		- City or Towr	n, State
HOLE MORE.	ages ent of nt: If i		tx☐ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Spec		Sp	emetery, crer ringhi	II Memory	Υ 4/28	3/05	Hebro	n. MD	
Shave Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Mantal Hygiene. Inpopriant: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic avent, the Medical Examiner must be notified at 90ce.		21. Signature of Funeral Service Live	-		Gafde 22						
ä	Depe Impo any ir		* Keth R L	heres CF	TP	H	followay	ss of Facility Funeral He Hill Rd.,	ome Pro	fession	nal Ass	ociation
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death	n. Do not ent	er the mode of dyin	ng, such as cardiac o	r respiratory ar	rest,	A	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition	- LVO	ov I A	+						Inset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	uence of):						
	Examiner		Sequentially list conditions	b. END	ST	AGE !	CHRONIC	OBSTRUCTI	VE PUL	MONTARY	DISE	IST-
	ק ק	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):					'	
	ite be executed sysicien and he burial-transit	cam	that initiated events resulting in death) Last	cDue to (or as		unnan of):						
760.	e be execut sicien and e burial-trar			Due to (or as	a consequ	uence oi).						
87	tificate ng physi as the	dical	•	d		· <u>-</u>						
×	eath certifica attending ph for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv				224 D	ate of delivery	
B	eath cer attendir I for use	clar	23b. Was decedent pregnent in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	Ideath 3	lEctopic pregnancy Other <i>(specify)</i>	′			onth Da	
O	that the de ed by the detached	lys	1 ☐ Yes 2 █ Ño 9 ☐ Unknown	9□ Unknown								
<u>a.</u>	Attending Physicien: The law requires that the death certificar refers. After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	Part II Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cor	ntribute to the	cause of death?
Į.	quire an sig	ed t	TYPE / DI	ABETES .	4				101	'es 2□No	3 Probab	ly 4 DUnknown
S	aw re	plet	(ENEBROVASCI)	LAR /	1661	DINI			24a. Was	an 24b.	Were autopsy	y findings available
ä	The lav	E o	HYDEDTERVIO	in .					autop perfo	rmed?	prior to comp death? 1 ☐ Yes 2 (letion of cause of
ital	ien: rrtifica	Be C	25. Was case referred to edical examiner?					26. Place of ∂eath			100 20	-
>	hysic nis ce I dire	To E	1 ☐ Yes 2 ♠ No	Hospital: 1 Inpatie	ent 2	ER/Outpatien	t 3 DOA Oth	er: 4 \ Nursing Hon	ne 5 ☐ Resid	lence 6 🗆 Ot	her (Specify)	
9	ing P	on:	27. Mannar of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injun Wor		8d. Describe h	low injury occu	rred	
Sio	tendi leath. tor: A	catl	2 Accident investigate 3 Suicide 6 Could not	ha -				Yes 2 □No				
Division of Vital Records. P.O. Box 68	or At after of Dirac in by	Certification:	4 ☐ Homicide determined		c. (Specify	ome, farm, str /)	eet, factory, office	2	281. Location (S City or Tow	Street and Num m. State)	ber or Rural R	loute Number,
-	Hospitel		29a. Certifier 1D Certifying P	hysician: To the best	of my know	wledge death	occurred at the tin	ne date and place a	and due to the	auco(a) and m	annor as state	
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Exe	miner: On the basis o	f examinal	tion and/or in	estigation, in my o	pinion, death occurre	ed at the time,	date and place	, and due to th	e cause(s)
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sign	ed (Month, Da	y, Year)
			- / / Mather A.	WI	1	11)	Di	060515		4/2/	155	
	4.0		30. Name and address of person who	completed cause of o	leath (Item	23a) (Type,	Print)	-0-0/-		1	1	
_	/ MM		NI-1HIMMARAYAPP	A MD 61	14 2	DATLI	N SHI	E DR	SALIS	BUKX	MI	2/804
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. 18 gistr	ar's Signa	ture	selle					,

DHMH 17 Rev 1/2001

T	State of Maryland / Department of Health and Mental Hygiene	DOE LEONO
	1- State of Waryland / Department of Health and Wentar Hygiene Registrar amend item #20B per fh g843 S friff Cats of Death Reg. No	000011000
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death
/Medical	DONTAY DWAYNE SMITH April 24,	2005 11:09 P M
Examiner	5000 P	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 19	ince George's 9. Birthplace (State or Foreign
Director	215-06-2086 1 M 2 F 22 Yrs. Months Days Hours Min. (Month, Day, Year) Usual Residence of Decedent	7 MARYLAND
yland yland	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
e Maried	MD PRINCE GEORGE'S NEW CARROLLTON	¥ Yes 2 □ No
with the Mar t or 28a-f st be notified Director	10e. Street and Number 10f. Zip Code 10g. Citi	izen of What Country?
0036 hours after death with the Maryland hours after death with the Maryland lural; or Itams 23a or 28a-1 show at Examiner must be notified at ed by Funeral Director	5328 85th AVENUE B-8 20784 U.s. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.)	S.A.
Safter d		 Race - American Indian, Black, White, etc.
21215-0036 by within 72 hours aft gione. If then "natural", or If the Medical Exami Completed by F		Specify: U.S.A.
21215-0 ed within 72 ho ygiene. Per than "natur it, the Madical I.	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	ind of Business/Industry
within ene.	Elementary/Secondary (0-12) College (1-4or 5+) 11th None No	na
	p 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden	
Aarylan 2 should be and Mental Is marked or aumatic ave		
re, Maryland s 1 and 2 should be file s Health and Mental Hy liam 27 Is marked oth other traumatic avent To Be (19a. Informant's Name/Relationship (Type, Print) ANNETTE SMITH/MOTHER 19b. Mailling Address (Street and Number or Rural Route Number, City or ANNETTE SMITH/MOTHER	
C = 64 F	3326 63Lii Avenue New Carrollton,M	
altimore, mit. Pages 1 a partiment of Hee portant: If itam y injury or othe	1 🔀 Burial 2 Cremation 3 Removal from State MARY (LAND AND AND AND AND AND AND AND AND AND	cation - City or Town, State
altin		over,Maryland s Funeral Home
Depa Depa Impo	7474 Landover Road Landover, M	faryland 20785
	23a. Part1. Enter the disease, or explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Ph sician	Immediate Cause (Final disease or condition resulting in death) a. gunshot wound of reck	Onset and Death
/Medical Examiner	Due to (or as a consequence of):	
ē E	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
o, executed an and rial-transit Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that intitated events C.	J.M.
8760, cate be executed ohysician and the burial-transit dical Examir	resulting in death) Last Due to (or as a consequence of):	
	d	
death certific death certific e attending p of for use as iclan/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	
Box death cert death cert attendin d for use	23b. Was decedent pregnant 25c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 yes 2 No 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
that the death certificate by the attending reletached for use as Physician/Me	9 Unknown 9 Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	se contribute to the cause of death?
cord	1 □ Yes 2 Ŋ	No 3 Probably 4 Unknown
Record The law requir te has been s age 2 should ompleted	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	12C/es 2L No	death? 1 XYes 2 □ No
	examiner? Lossital:	Source (a company)
Division of lor Attending Phy after death. Director: After this in by the funeral d in by the funeral d ertification; Te		
Vision Attending r death. sector: After by the fune	1 Natural 5 Pending (Montin, Day Year) Injury Work? 2 Accident investigation 4-27-05 230-7 M 1 Yes 2 No Subject	shot
Division (lal or Attending P rs after death. al Director: After 1 ed in by the funers Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)	
ospital hours uneral ily filled		n St., Bladensburg, MD
H 22 H	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.	place, and due to the cause(s)
within 2 To the complete	20h Cignature and title of partition	e signed (Month, Day, Year)
	Matri aronica-Tollah no OCME April	25, 2005
2 (2)	30-Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State	TATRICIA ACONICA - TOTAL MD 111 Penn Street Baltimore, 31. Date filed (Month, Day, Year) 2. Registrar's Signature	Maryland 21201
State Registrar	APR 2 7 2005 Keeter & Smile	

			1 - For State Registrar	State of Ma	aryland		artment of H tificate of L			Reg	erie 0 0 5	15809
	Physici /Medic		Decedent's Name (First, Middle, Last, Milton Schwartz							te of Death onth il 2	3 2005	3. Time of Death 3:50 P M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		Death		4c. County of Death	
L			1111 University B1			A 6 (Ab do 1)	Silver S	pring If Under 2	4 Hrs. I a. D.		Montgomery	
	Funeral Director		5. Social Security Number 113-20-3262 Usual Residence of Decedent	M 2□F	0 (In yrs. las 76	Yrs.	Months Days	Hours	Min. 8. Da (Mc 02 /	te of Birth onth, Day, Y 11/19	(ear) 9. Birth Cou	place (State or Foreign ntry) NY
	yland		10a. State 10b. County		-	Town or Lo						10d. Inside City Limits
	e Mar	ctor	MD Montgome	ry	Silv	er Sp	ring					1. Yes 2 No
	th with th	al Director	10e. Street and Number 11111 University B1	vd W Apt-	1008		10f. Zip Code 20902			10g U	g. Citizen of What Cou Inited Stat	ntry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Exam for must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origi n, Mexican, Specify:	in? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
715-U	hin 72 ho n."natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		4)	16a. Deced (Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most	of working	16	3b. Kind of Business/Ir	ndustry
77	filed with Hygiene other the	Com	12	College (1-40) 5	*,	Owne	r/Operato	r		R	etail Stor	·e
Maryland 21215-0036	should be file and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Abraham Schwartz						's Name (First, Unknow		aiden Sumame)	
	permit. Pages 1 and 2 should be fill Department of Heelth and Mental H Important: If item 27 is marked out any Injury or giber traumatic even once.		19a. Informant's Name/Relationship (Ty Laura Schwartz - W								City or Town, State, Zip Silver Sp	2.117112
Baltimore,	Pages 1 and of He not of H		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F	lemoval from State	cen	netery, crer	sition (Name of natory or other place	' 1	Date		c. Location - City or T	
	t. Pag ntment rtant:		`4 ☐Donation 5 ☐ Other (Specify)	A	Mt.		on Cemete				delphi, MD	
g	permit. Departrimporta		21. Signature of Egneral Service Lice	D tops	JCF	SOF	Name and Addressines—Rina	ldi Fu	uneral	Home,	Inc	, MD 20904
į.	Fnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin a Lung C	_{e.} ancer	Do not ent			**			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	a conseque	nce of):						
	and erransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes or injury that initiated events resulting in death) Last	Due to (or as a								
68/6 0,	ficate be executed physician and is the burial-transit	dicai	Į,	d	2 001130443							
O. Box	it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 □ Live birth 1 □ 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year
ecords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death bu	it not result	ing in the u	nderlying cause give	n in Part I.	23		cco use contribute to t	
r	The law ate has b page 2 s	Completed								a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	05	2/0	Othe	r	of Death (Chec			
ion of	ding h. After fune	 -	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2	R/Outpatien 8b. Time of Injury	28c. Injury Work	at Nurs	28d. De	-	ce 6 □Other (Special injury occurred	(y)
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hom :. (Specify)	e, farm, str	eet, factory, office			cation (Streety or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or within 24 hours af To the Funerel D Completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Phy. 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred at the time vestigation, in my op	e, date and inion, death	place, and due occurred at th	e to the cau	se(s) and manner as s a and place, and due to	tated. o the cause(s)
	To the Within 24	Σ	29b. Signature and title of certifier	0. 0)		29c. License				I. Date signed (Month,	
	5		I faul	rame	0	787-4-00	Doo	610	83	/4	PRIL 24,	2005
			30. Name and address of person who co Paul M Thambi, MD	9707 Medi	cal C	Center	Dr Rocky	ille.	MD 208	850		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 200	32 Registra	ar's Signatu	re Apa	ule					

DHMH 17 Rev 1/2001

			1 _ State	nd / Department of I		-	01061 600
			1. Decedent's Name (First, Middle, Last)	Certificate of		Reg. No Date of Death	3. Time of Death
	Physici /Medic		Fannie Steinberg		A	Month Day	y Year 200 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death		County of Death
			Montgomery General His	pital Olney	MIS		lontgemery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	(Iast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min.	Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent			5-28-19	117
	ryland show	L	10a. State 10b. County 10c. Ci	ity, Town or Location			10d. Inside City Limits
	8a-fs	Director	MD Montgomery 51	Ner Spring	7		1 X Yes 2 □ No
	ours after death with the Marylar ral', or Items 23e or 28a-f show Examiner must be notified at	Dire	10e. Street and Number	10fr. Zip Code		10g. Cit	izen of What Country?
	leath ns 23	Funerai	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of I	10 Q	Yes or No-	14. Race - American Indian,
9	after deat or items:	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No	If Yes, specify Cub	Hispanic Origin? (Specify lan, Mexican, Puerto Ricar	n, etc.)	Black, White, etc.
003	hours after death with the Maryland tural; or items 23e or 28e-f show al Examinat must be multised at	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🏋 No	Specify:		Specify: White
15-("ned	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. K	ind of Business/Industry
12	be filed within tal Hygiene. Id other than "	omp	Elementary/Secondary (0-12) College (1-4or 5+) 12	Manager	0)	Ret	tail
DE 2	e filed Il Hygir other vent, L	Be C	17. Father's Name (First, Middle, Last)	Tanagor	18. Mother's Name (First		
/lar		To B	Joseph Peckerman		Nadia Tobia	n	
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) Susan Gordon – Daughter	19b. Mailing Address (Street 18244 Windson			
	of Health item 27 I		20a. Method of Disposition 20b.	Place of Disposition (Name of	Date		ocation - City or Town, State
OE I	Pages nent of l int: If its			cemetery, crematory`or other pla • Lincoln Crema		005 Bren	twood, MD
Baftimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Livensee	22. Name and Addre	ess of Facility	Home, In	ac
			23a. Part1. Enter the disease, or complications that caused the dea				r Spring, MD 20904 Approximate
	Constant on	g:	shock, or heart failure. List only one cause on each line. Immediate Cause (Final			priarry arrost,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consection)	quence of):			5 days
8	Examiner		Sequentially list conditions	ellulitis			Iweek
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):			
_	and and I-trans	Examine	Cause (Lisades or injury that initiated events resulting in death) Last Due to (or as a consec	quence of):			
8760,	death certificate be executed to attending physician and ad for use as the burial-transit	dicai E		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
9	ificate g phy: as the	edic	0.				
Вох	eath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta		.,		23d. Date of delivery
	it the deal by the att	Physician/Me	in the past 12 months? 1				Month Day Year
P.0	that the ed by th detache		Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause on	on in Part I	23a Did tabacco	use contribute to the cause of death?
ds,	uires tha signed id be de	d by	Chronic Obstructure	1	120100	1 ☐ Yes 2	_
COL	w requir been si should	iete	Parternagor's dia	20.40		24a. Was an	24b. Were autopsy findings available
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed		ecop.		autopsy performed? ☐ Yes 2X No	prior to completion of cause of
ital		Be C	25. Was case referred to medical examiner?		26. Place of Death (Che		10103 2010
of V	Physicien: r this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	JETVOdipatient 30 DOA	er: 4 Nursing Home	5 Residence	6 □Other (Specify)
nc	ing After une	ion:	27. Manner of Death 1 Affatura? 5 Pending (Month, Day Year)	28b. Time of 28c. Injury Wor	ryat 28d.[rk? Yes 2 □ No	Describe how injur	y occurred
Division	E T B	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At h			ocation (Street an	d Number or Rural Route Number.
D	itel or irs after rel Dire	Certification:		nome, farm, street, factory, office ify)		City or Town, State	
	To the Hospitel or Atte within 24 hours atter de To the Funerel Directo completely filled in by th	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kni and manner stated.	owledge, death occurred at the tra ation and/or investigation, in my o	me, date and place, and d opinion, death occurred at	ue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. Licens			te signed (Month, Day, Year)
	12		I mendlirally	D3	8262	A	mi 23,200 (
	-		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, Print)	8262 1 BWD SU	1-2-	20850
	Sta	te.		40/ Research	n ISWD SU	ule 330	Rockullenin
	Registr		31. Date filed (Month, Day, Year) APR 2 6 2005	Apara			

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 5 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month GEORGE THOMAS SHIELDS AM /Medical Apri 30,2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CUMBERAND

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, MAY 29, ALLEG HEART OSPITAL SACRED ANY 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F MARYLAND 76 Director 217-24-5946 Yrs Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location ir Items 23e or 28e-f show 10d. Inside City Limits Director GARRETT 1 ☐ Yes 2 No ACCIDENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28761 GARRETT HIGHWAY 21520 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: treumatic event, the Mudical Exam Specify. WHITE 3 ☐ Widowed 4 ☐ Divorced nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygiene Importent: If item 27 is marked other the eny injury or other treumatic event, Italy once. CONSTRUCTION WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE THOMAS SHIELDS, SR. THERESA ELIZABETH FOX 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SHIELDS - WIFE 28761 GARRETT HIGHWAY ACCIDENT, MD 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRETT MEMORIAL GARDS. 5/4/05 * 4 □Donation 5 □ Other (Specify) OAKLAND, MARYLAND Funeral Service Liv 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia 3 044 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Prospete Melostorio C monte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? certificate 1 Yes 2 No 2□ No Division of Vital 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient s after dea... 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) 30 J+VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFAQ AHMAD, M.D. 625 KENT AVENUE CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Deborah Ann 12:50 PM Shreve /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. CART HILL GAN SACREC Birthplace (State or Foreign Country)
West Virginia 5. Social Security Number Age (in yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Days 1 □ M 2 🗓 F 49 214-62-2702 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it if them 27 is marked other than "natural", or Items 23e or 28e-f show and it if them 27 is marked other than "natural", or Internative availies at any or other traumatic event, the Modical Exciniter must be availied at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits WV. Mineral Keyser 1 TYAS 28 NO Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RR 6, Box 6333 26726 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes XXNo 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) School System secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Junior J. Armentrout Beatrice R. Beeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Shreve/ husband RR 6, Box 6333, Keyser, West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/02/ Potomac Mem. Gardens Keyser, West Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ent nervous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has blirector, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: A

Medical Certification: 6 Could not be determined 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number hannes

29d, Date signed (Month, Day, Year)

cumberland

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 92

32. Registrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 05 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year :450M hevs veroma 2005 Apri 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Frederick Healthcare Fredlick center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 ☐ M 2 🔀 F Director 216-30-5412 72 Burkittsville MD Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examinar must be notified at 10d. Inside City Limits MD Frederick Brunswick Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "I" Street 37 West 21716 USA death Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" ...", any injury or other traumatic evon... 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Providence Hospital 10 Nurse Baltimore, MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Jerome Smothers, Sr. Mae Emma Grayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis E. Stockton, Son 1902B Jefferson Pike, Knoxville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State St. Mary's Cemetery 4/28/2005 * 4 ☐ Dorightion 5 ☐ Other (Specify) Petersville, MD 21. Signature of Furbral Service Licensee 7
Barbara A. Williams, 22. Name and Address of Facility Owner John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End stage Cinomiobstrutive pulmonary Physician disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (U) as a consequence of the attending physician and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à ardiovascular disease 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director 26. Place of Death Check onl one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After ti 28b. Time of 28d. Describe how injury occurred Natural 5 Pending М investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mono. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE., BRUNSWICK, MOZIDI6 CHAN-HING HO M.D 610 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** James Tichinel 9:56 am 26, 2005 /Medical April 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2738 Walnut Bottom Rd. Garrett

9. Birthplace (State or Foreign Country) Swanton I I Under 24 Ars. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 215 05 2093 Director Aug 21 1915 MD Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Interest if Item 27 is marked other than "naturel", or Itema 23e or 28e-f show ary or other traumetic event, the Medical Examinal must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21561 2738 Walnut Bottom Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Coal 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B George Tichinel Lizzie Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Tichinel 2738 Walnut Bottom Rd. Swanton, MD 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Department of Important: if any injury or once. 4 Donation 5 Other (Specify) Turner Cemetery Apr. 29, US Walliut Px 22. Name and Address of Facility Burdock Funeral Home Apr. 29, 05 Walnut Bottom, MD 21. Signature of Funeral Service Licensee 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OR Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final menia disease or condition resulting in death) Examiner Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): within 24 hours after deeth.

To the Funerei Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 YNo 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√ No Medicai Certification: To Residence 6 Other (Specify) 28d. Pribe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year, 28b. Time of 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 21562 Maryland 90 Main St., Dr. Shin Eung Kim, Westernport 31. Date filed (Month, Day, Year) APR 2 8 2005 32. Registrer's Signature State Registrar

			1 - For State of Maryla	nd / Depa		lealth and	Mental Hygi	-	15815
			Registrer 1. Decedent's Name (First, Middle, Last)	Cei	runcate or	Death		g. No.	10010
п	Physici	an					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Melvin Arthur Tyler					, 2005	18:08 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)			or Location of Deat	h	4c. County of Death	
			Prince George's Community Hosp 5. Social Security Number 6. Sex 7. Age (In yrs		Chever1	If Under 24 Hrs		Prince Geo	rge's
г	Funeral		1 M144 20 5	s. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,	(ear) 9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent				Aug. 15,	1922 Mary	land
	/land		10a. State 10b. County 10c. C	ity, Town or Lo	ocation			1	0d. Inside City Limits
	Man F st	ţo	Maryland Prince George's Ca	anitol	Heights				1 ☐ Yes 2 X No
	r 28e	jec	10e. Street and Number	th I co I	10f. Zip Code		10	g. Citizen of What Cour	itry?
	h witi	Funeral Director	900 Highview Drive		20743		He	ited State	·
	ms 2	Jer	11. Marital Status 12. Was Decedent Ever in 8	J.S. 13.	Was Decedent of H	lispanic Origin? (S		14. Race - Americ	an Indian,
9	after or Ite		1 ☐ Never Married 2 Å Married		If Yes, specify Cub:		o Rican, etc.)	Black, White,	etc.
င္တ	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Evantreer must be notified at	1 by	3 Widowed 4 Divorced Year or Dates:		TU Yes 26 No	Specify:		Specify: Whi	te
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygliene. od other then "naturel", or Items 23a or 28a-f show event, the Madical Exaction mad be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decer	dent's Usual Occup	ation	rking 1	6b. Kind of Business/Inc	Justry
21	within ene. then *	idu	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retire				
7	e filed within al Hygiene. other then ' vent, the Me	CO	6	Ir	on Worker			Constructi	on
힡	d be fill antal H ted oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	ne (First, Middle, Ma	aiden Sumame)	
<u>ya</u>	ould Men Marke	은	Arthur B. Tyler		_		<u>Durnbauc</u>		
Maryland	s 1 and 2 should I Health and Men item 27 is merke other treumatic		19a. Informant's Name/Relationship (Type, Print)		1900			City or Town, State, Zip	
-	os 1 and of Health item 27 other t		Ida Mary Tyler-wife	900	Highview	Drive, (ights, MD	
ō	0 0			cemetery, crer	osition (Name of matory or other place	ce)	Date 26	c. Location - City or To	wn, State
Baltimore,	permit. Pag Department Importent: I any injury o	17	'4 □Donation 5 □Other (Specify)		ns' Cemet		8-2005 C	heltenham,	Maryland
33	Deparition Department Importment		21. Signatur det Euneral Service Licensee M01391	22	2. Name and Addre Huntt Fur	ess of Facility	10		0)22
	707 e 0		23a. Part 1. Enter the disease, or complications that caused the dea		P.O. Box	156. Wal	dorf, MD	20604-0156	
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause or pach line.	ith. Do not ent	ter the mode of dyir	ng, such ås cardiad	or respiratory arres	t,	Approximate Interval Between
	Enysician	31	Immediate Cause (Final disease or condition	25					Onset and Death
	/Medical Examiner		resulting in death) Due or as a conse	quence of):					
6	- S	L	Sequentially list conditions, b.	my	on	a.	_	2	
	ed sit	ine	Sequentially list conditions, if any, leading to immediate outse. Entar Underlying Cause (Disease or injury that initiated events	quence of):	11:11	/	2 11		
	and and I-tran	Examine	that initiated events resulting in death) Last	omence of).	Capital .	and	- Co	7	
8760,	ate be executed hysician and the burial-transit	ical E		quonos or):	- 12	- la	- 2	20226	
			d.,	-	100		7		
9 X	eath certific attending p for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregr	ancy					
Box	atten for u	cian	in the past 12 months?	tal déath 3□	Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	ry Day Year
P.O.	that the ded by the detached	ıysi	1 Yes 2 No 9 Unknown 9 Unknown	death 5					
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not re	Salting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ds	uires 1 sigr 1d be	d by	Deneil Farke	nd		\ \ \		2 No 3 Prob	1
00	w require been signature	lete	Dening of the	1/2	1-	0 0	240 1450 00	04h W	
Vital Records,	The lay	Completed	Jergenst gwood	1	wale	and the same	24a. Was an autopsy performe	prior to con	osy findings available npletion of cause of
ल		e Co	25. Was case referred to me incal	MARS	evo		1 □ Yes 2		2□ No
	Physicien: this certific ral director,	o Be	examiner?	750/0	. act and Oth		th Check on e		
of	문 두 등	\vdash	27. Manner of Death 28a, the of Injury	ER/Outpatien 28b. Time of	" SEI DON	4 C Indianing I	ome 5 ☐ Residen 28d. Describe how	ce 6 Other (Specify)
on	ttending F death, stor: After	tlor	1 Natural 5 ☐ Pending (Month, Day Year) Accident investigation	Injury	Wor	k? Yes 2∐No		,, 00001100	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At 1	home, farm, str			28f. Location (Stre	et and Number or Rura	I Route Number.
Ö	after after Direct	erti	4 Homicide determined building, etc. (Spec	ify)			City or Town,		
	To the Hospitel or Ai within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier Certifying Physician: To the best of my kn	owledge, death	h occurred at the tir	me, date and place	, and due to the cau	se(s) and manner as st	ated.
	the Ho hin 24 t the Fu npletely	edical	(Check only (Check only one) Medical Exeminer: On the basis of examination and manner stated.	ation and/or inv	vestigation, in my o	pinion, death occu	rred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. Licens	e number	290	I. Date signed (Month, I	Day (Year)
			> / fulou		0	3031	8	4/2210	35
5	٠,		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,				4	
	0851		James Catevenis, MD, 3001 Ho	spital	Drive. C	heverly	MD 20785		
	Sta	-	31. Date filed (Month, Day, Year) 32. Regulars Sign	lature &	Acres .	1121211] \$	TIP EUI OU		
	Registr	ar	APR & D ZUUD JOHNER	· 10 ,	your				

				epartment of Health and M Certificate of Death	lental Hygiene	005 58 6
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Paul T.Utz Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Year 2005 3. Time of Death $11:00 \mathrm{A}\mathrm{M}$
	Funeral Director		3371 Littlestown Pike 5. Social Security Number 6. Sex 1 M 2 F 51 V Usual Residence of Decedent	Westminster day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth June 20,1	Carroll 9. Birthplace (State or Foreign
	the Maryland r 28a-f show	Director	10a. State 10b. County 10c. City, Town	or Location ninster	10g. Citiz	10d. Inside City Limits 1 ☐ Yes 2 ☐ No sen of What Country?
36	d within 72 hours after death with the Maryland Jiene. I than "natural", or itams 23a or 28a-f show The Madical Evanti mermaat ke malified at	by Funeral DI	3371 Littlestown Pike 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21157 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-Rican, etc.)	ŕ
Maryland 21215-0036	ss 1 and 2 should be filed within of Health and Mental Hygiene. If Iam 27 is marked othar than "r othar traumatic event, the Mar	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8	Decedent's Usual Occupation Give kind of work done during most of worki ife. DO NOT use retired) andscape	P1	nd of Business/Industry ant-Trees Nurser
laryland		To Be	17. Father's Name (First, Middle, Last) Paul T.Utz Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. I		e (First, Middle, Maiden S hanefelte al Route Number, City or	r
Baltimore, M			Mary Utz-Mother 20a. Method of Disposition 1	crematory or other place)	Date 20c. Loc	stminster,MD2115 cation · City or Town, State mpstead,MD21074
Balt	permit. Page Department: Important: It any injury o		21. Signature of Funeral Service Licensee Puh and Luttle 23a. Partl. Enter the disease, or complications that £ used in death. Do no	22. Name and Address of Facility Little's FH 34 M	aple Ave.	
8760,	death certificate be executed Exam Medical e attending physician and ider use as the burial-transit	lical Examiner	shock, or heart failure. List only one caus son let child immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listed events resulting in death) Last Due to (or as a consequence of consequ	tic Vine	f A	Approximate Interval Batwen Opea and Death
.O. Box 6	that the death certifica led by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	20	3d. Date of delivery Month Day Year
ords, P	requires een sign nould be	ompleted by Pl	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
of Vital Record	The la ete has page 2	Be Compl	25. Was case referred to medical examiner?	26. Place of Death		24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Division of \	tending Physicath. tor: After this the funeral dir	ertification; To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	ne of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury 28f. Location (Street and	Other (Specify) occurred Number or Rural Route Number,
ā	lospital t hours unaral	edical Cert	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/and and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	City or Town, State) and due to the cause(s) a ed at the time, date and p	and manner as stated. place, and due to the cause(s)
	To the Hos	Med	29b. Signature and title of certifier	29c. License number D 3 5 3 9 8	29d. Date	signed (Month, Day, Year)
	Sta Registr		30. Name of address of person o completed cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause of death (Item 23a) (The Principle of the Completed Cause o	en Center Street L	itainta (w. HD21157

ian cal	1. Decedent's Name (First, Middl			rtificate of		2. Date of Dea Month	th Day Year	3. Time of Death
200		meta Coree		ington			21, 2005	12:31 A.
ner	4a. Facility Name (If not institution				or Location of Death		4c. County of De	
	Washington Ad 5. Social Security Number		PICAL Age (In yrs. last birthday	Takoma If Under 1 Year		8. Date of Birth	Montgo	omery inthplace (State or Foreig
	578-26-2837 Usual Residence of Decedent	1□M 2 X F	84 Yrs.	Months Days		8. Date of Birth (Month, Day August		Country) irginia
L	10a. State 10b. County		10c. City, Town or L	ocation			-	10d. Inside City Limit
Director		gomery	Sil	lver Spri	ng			1 X Yes 2□N
	10e. Street and Number	-Li- Dil		10f. Zip Code	04		Og. Citizen of What C	•
Funeral	12801 Old Colu	12. Was Deceden		Was Decedent of	ates nerican Indian,			
2	t ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
eted	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece	edent's Usual Occu	pation during most of work d)	ina	16b. Kind of Busines	•
Completed	Elementary/Secondary (0-12)	College (1-4or	(5+) life.	Office		ł	U.S.Dept. Selective	of Defense
e C	17. Father's Name (First, Middle,	-		OTTICE	18. Mother's Name			pervices
To B	Charles How	ard Coles			Emma .	Jane Ma	rks	
_	19a. Informant's Name/Relations George Washingt	hip (Type Print)	ah and 19b. Mail	ing Address (Street				Zip Code) 20906
	Patricia Ann Gr		er) 1371	3 Town L	ine Road;	Silver	Spring, Ma	ryland
	20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce) Apri	29,200	20c. Location - City o	r Town, State
	*4 □Donation 5 □ Other (S	pecify)	Maryland				Laurel, Ma	
	21. Signature of Funeral Service	Licenses An	1/2	R. N. HO	rton Compa	ny Mort	icians, In	nc. DC.20011
	23a. Part1. Enter the disease, or	complications that cause	ed the death. Do not en					Approximate
	Immediate Cause (Final	only one cause on each	llub o	Via				Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or a	s a sins suance of):	IUA				
		b	U Dl	nual	offer	SUM		
Jer	Sequentially list conditions							
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xaminer	if any, leading to immediate	c	- 6	MUL	of leer	dencu	n Orgen	
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Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Undertying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investignations Pending investignations 29 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Medical 29b. Signature and title of certifier	Due to (or a: d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown ons contributing to death Hospital: 1 Inpat 28a. Date of Inj (Month, D) aption not be lined 28e. Place of Inf building, e g Physician: To the basis and manners	e of pregnancy 2 Fetal death at time of death 5 but not resulting in the the control of the cont	other (specify)	26. Place of Death OP: 4 Nursing Hory at K? Yes 2 No	23e. Did tob 1 Ye 24a. Was an autops: perform 1 Yes 2 1 (Check only one me 5 Reside 28d. Describe ho 28l. Location (Str. City or Town and due to the ca	23d. Date of de Month Dacco use contribute to see 2 No 3 Per Per No 1 Per	Day Year To the cause of death? Trobably 4 Tonknown Utopsy findings available completion of cause of s 2 No Pocify) Tural Route Number, s stated. e to the cause(s)
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State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15818 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day FOSTER BENSON WEST 2005 APRIL 25 12:22 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IAGO AVENUE 1116 CAPITOL HEIGHTS PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Yeal) 948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 12XM 2□F Director 579-58-6954 57 **February** Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinating must be notified at 10d. Inside City Limits 1 ▼ Yes 2 No Prince George's Capitol Heights Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1116 Iago Avenue 20743 U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Marines 1 ★ Yes. 2 Noarines If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 T Married 1 ☐ Yes 2 No Specify. Š Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government llth Fork Lift Operator permit. Pegas 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shirley G. Gray Benson Pollard West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1116 Iago Avenue Capitol Heights, Maryland 20743 Marguerite O. Bell-West/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from-4/29/05 Maryland Veterans Cheltenham, Maryland * 4 □ Donation 5 □ Other (S 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Septice Licensee 13 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or conscilications that caused the death. Do not unter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (2016) Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2X No 1 Yes 2 X No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 T Accident illed in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical mariner stated 29c. License number 29b. Signature and tik a of pertifie 29d. Date signed (Month, Day, Year) 00037529 April 26, 2005 person who completed cause of death (15 m 2 a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

APR 2 7 2005

Ron Wheeler M.D.

1221 Mercantile Lane Largo, Maryland 20774

			For State Registrar		State of M	aryland		artmen rtificate				•	giene Reg. No	6002	15819
			1. Decedent's Name (First, A	liddle, Last))							2. Date of De	ath		3. Time of Death
	Physici		John S		Wilburn,	Jr.						Month April	24		12:48 P ^M
)	/Medic Examin		4a. Facility Name (If not instit					4b. City,	Town, or	Location of	of Death	19111		. County of Dea	
			6001 Muncast	er Ro	ad-Casev	House		Ro	ckvi	11e				Montgom	er.
	Funeral		5. Social Security Number	6. Se	x. 7. Ac	ge (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Bir (Month, Da			thplace (State or Foreign ountry)
	Director		220-28-5796	1)2	M 2□F	73	Yrs.	Months	Days	Hours	Min.	Jan. 26	y, Year	32 Was	hington,D.C.
	p		Usual Residence of Deceder	t								000111		-52 Mab	inigeon, b.c.
	irylar ihow		10a. State 10b. Co	unty		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	6 Ma	cto	Md. Mo	ntgom	ery	Roc	ckvil	le							1 ☐ Yes 2 No
	ith th	by Funerai Director	10e. Street and Number					10f. Zip	Code				10g. Ci	itizen of What Co	ountry?
	23e	ai	4311 Sunflow	er Dr	ive					208	353		Ur	nited St	ates
	ems ems	nue	11. Marital Status		12. Was Decedent Armed Forces	?	13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
98	or II	YFL	1 Never Married 2 🔀		1 X Yes 2 ☐ If Yes, Give	No		1 ☐ Yes		Specify:		. ,			White
21215-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-1 show disal Exarcillet must be indiffed at	q p	3 Widowed 4 Divo		Year or Dates:	Korea	an		111					opecity.	wiiice
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Maryland	ntal I	Be		lburn	Cr							Gibbo		i Sumame)	
Ž	hould d Me mark mark	ပ္	19a. Informant's Name/Rela				10b Maili	na Addross	(Street e		ncy			an Taura Cana	7:- O- d-)
N S	d2s th an 7 is 1							_					,	or Town, State,	
9	1 an Heali em 2 ther		June M. Wilbs 20a. Method of Disposition	ш1 /	wite	20b. Plac		Sition (Nan		er br		Rockvi		ocation - City or	20853
چ	of H		1 ☐ Burial 2 🗷 Cremat		Removal from State	ce <i>r</i> r	netery, cre	matory or or	ther plac						
Baltimore,	rtmer rtmer rtent		`4 □Donation 5 □Oth			Met		litan				5/05		lexandri	La, Va.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show minipury or other treumatic event, the Martical Examinet must be notified at once.		21. Signature of Funeral Ser) C	Bash	20 -	_ 2					Funer			
	40144		" " face	P 74	1 Sara			Р.	0.	Box 5	5038,	Layto	nsvi	ille, Mo	
			23a. Part1. Enter the diseas shock, or heart failure.	e, or compl List only o	ications that cause ne cause on each l	d the death. ine.	Do not en	ter the mode	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	92	a. NOI	N HODG	KIN'S	LYMP	HOMP	1					MONTHS
	/Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):								
		_	Sequentially list conditions,		b		0								
	pe lisi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as	a conseque	nce or):								
	and I-tran	хап	that initiated events resulting in death) Last		Due to (or as	a conseque	nce of).								
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87	physi the	dical		-	d										
9 xo	death certific attending p	Physician/Me	IF FEMALE:	2	23c. If yes, outcome	of pregnance	· ·								
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0	requires that the deen signed by the nould be detached	Ph	Part II. Other significant cor	ditions co	ntributing to death I	out not resulti	ing in the u	nderlying c	ause dive	on in Part I		23e Did to	obacco	use contribute to	the cause of death?
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<u></u>	That a se	Col										1 ☐ Yes	rmed? 2 Z No	death? 1 ☐ Yes	2 □ No
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n o	ng ffer	Certification:	27. Manner of Death 1 X Natural 5 □ Pe		28a. Date of Injui	ay Year) 28	8b. Time o Injury		8c. Injury Work			28d. Describe h	now inju	ry occurred	
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Division	in the	ıı		termined	28e. Place of In building, e	tc. (Specify)	e, farm, st	reet, factory	, office		2	28t. Location (S City or Tov	Street al vn, State	nd Number or Ru e)	ural Route Number,
	Hospitel or 4 hours afte Funerel Dir tely filled in														
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	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one) 29b. Signature and title of ce		and manner s	aled.				number					
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	•		30. Name and address of be												
			CHITRA RAJA 31. Date filed (Month, Day,)						ILIP	DRIV	Æ, C	LNEY, I	D.	20832	
	Sta Registi		APR 2		Regist Slave	iai s Signatur	Bos	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph Arthur Wilson Day Year **Physician** 6:07 PM APRIL 29 2005 /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 219-14-6631 78 Director May 13, 1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or Itams 23a or 28e-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28e-f show traumatic event, the Medical Examinations to notified at Maryland Baltimore **Baltimore** 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 East 29th Street 21218 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Labor 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Beeman Joseph Wilson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) p+rmit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or other trai Marion Virginia Wilson-Wife 620 East 29th Street, Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 04, 1 Burial 2 □ Cremation 3 □ Removal from State Midland, Maryland St. Josephs Cemetery 2005 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenşee 22. Name and Address of Facility Eichhorn McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 2 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ISCHEMIC CARDIOMYOPATHY YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL FAILURE ACUTE Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence off Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 XNo 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funerel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946-E37 APRIL, 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY PARKWAY, BALTIMORE, MARYLAND 21218 AGARWAL, MO 201 EAST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY - 3 2005 Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of M	aryland		artment of H		nd Mer		iene	005)	15821
			1. Decedent's Name (First, Middle, La	st)						Date of Deat	th			3. Time of Death
	Physicia /Medic		SAMUEL E		WR	OTE	N		A	PRIL	Day 25,	7005	ır	9:40PM
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o		Death		4c. (County of De		-
			Howard County Ger			- 1 h / - t - 1 - 1	Colum		Urc o			Howar		
ı	Funeral Director		5. Social Security Number 6. S 217-01-6970	ex SgtM 2□F 7.AS	96 (In yrs. 16 88	ast birthday) Yrs.	Months Days		Min.	Date of Birth (Month, Day, ept. 2	Year)		Country	ce (State or Foreign 1) 1and
	ס		Usual Residence of Decedent		00			J		ept. 2	2, I	910 F	iai y	Tanu
	irylan ihow	_	10a. State 10b. County		10c. City	, Town or Lo							100	I. Inside City Limits
	Ba-f a	Director	Maryland Howar	-d		ETT	Lcott Cit	У						1 ☐ Yes 2 反 No
	with the		10e. Street and Number	. D. 1			10f. Zip Code	010/0		1	-	en of What		
	eath ne 23	erai	3004 North Ric	12. Was Decedent	Ever in 119	12		21043	n2 (Specific	Vos os No		ted St		
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ğ	ral', o	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WW	II	1 ☐ Yes 2 ☒ No	Specify:				Specify:	Whi	te
2	filed within 72 hours after death with the Maryland Hygiene, the than "natural", or Iteme 23e or 28e-f show ant, the Macifeal Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	dent's Usual Occup kind of work done	durina most o	of working		16b. Kin	d of Busines	ss/Indu	stry
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Maryland 21215-0036	fental fental rked tic ev	To B	Charles	Wroten				Loui	se	Ade	elman	n		
ary	and h		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Ro	oute Number	, City or	Town, State	, Zip C	ode)
Σ 3.	and sealth m 27	-	Barbara V. Wrote	n Wife			North R	idge R						21043
ore	ges 1 If ital or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from State	ce	metery, crei	sition (Name of matory or other place		Date			ation - City of		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene. Instruction: If time 27 is marked other than "natural; or theme 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once.	1	' 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Liger		Mead		ge Mem.							
Ba	Depa Impo any l		21. Signature of Furneral Service Light	any		I I	Name and Addre Burrier-Q 212 W. O	ueen Fi 1d Lib	unera erty	1 Home Road	& (Win:	Cremat Field,	ory MD	PA 21784
П			23a. P rt1 Enter the disease, or com how, or heart failure. List only	plications that cause one cause on each li	d the death	. Do not ent	er the mode of dyir	ng, such as ca	rdiac or re	spiratory arre	est,		10	pproximate iterval Between
	Priysician		Imaate Cause (Final d set se or condition	a ACLI	TE	myi	CARDI	M I	INF	ARCTI	CON			Inset and Death
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× 6	eath certific attending p	√Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncy					1 2	3d. Date of d	aliven	
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>	′			2	Month Month	D	ay Year
P.O.	at the de by the a	hys	9 Unknown	9□ Unknown										
	w requires that been signed I should be det	by P	Part II. Other significant conditions of	ontributing to death b	out not resu	lting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco us	/		cause of death?
ord	requir een si nould	ted							_	1 🗆 Ye	s 200	K lo 3□I	Probab	ly 4 □Unknown
Records,	e law has b	Completed							_	24a. Was ar autops	v	prior to	o comp	findings available letion of cause of
_	icien: The l certificate ha									perform	No	death?	s 21	□ No
Viita	ysicien: is certific director.	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	25/5	D/O-11	t all post Oth	05		heck only on				
o	g Phy er this eral d	n: To	27. Manner of Death	1 ☐ Inpation	ıry	P/Outpatier 28b. Time of	28c. Injur	y at		5 Reside			ecify)	
o	Attanding or death. actor: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	M 1 □	k? Yes 2 ∐ No	,					
Division of	r Atta	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	288. Place of in	jury - At hor	ne, farm, str	eet, factory, office		28f.	Location (St.	reet and , State)	Number or I	Pural F	loute Number,
	urs aft													
	To the Hospital or Attanding Physicien: within 24 hours after death. To tha Funarel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Vertifying Ph (Check only one) 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	t examinati	rledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death (place, and occurred a	due to the ca t the time, da	iuse(s) a ate and p	ind manner a place, and di	as state	ed. e cause(s)
	To t Com	Σ	29b. Signature and title of certifier	inn			29c. Licens	e number			_	signed (Mor		
	WIL		Frigues	עיו			05	2781	1	f	TYIZ	1 29	1	005
	GTIVA		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type,	Print) ITE	NNET	H G	EHY	120	> 1		
	. Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	lie ear	CITC !!			11	<u></u>			
	Registr	ar *	APR 2 7	2005	en	#	book							
				-										

			Please 1	Type or Print in Bla	ck Indelil	ole Ink. Ensure	All Copies	Are Le	gible.	
			For State Registrar	State of Maryland		ent of Health and ate of Death		6. 0	05	15822
			Registrar 1. Decedent's Name (First, Middle, Las	*1	Certinic	ale of Dealif	2. Date of De	Reg. No.		3. Time of Death
	Physici	an	Via a a la di	Willian	05		Month	Day	Year	02.17 M
	/Medic		4a. Facility Name (If not institution, give	,		ity, Town, or Location of Dea	HPRI		2005	0211
	Examir	er	Parin III Ran IAMA	/ Modini Pon	la/ 40.0	LALILALIA	•		1/ runic	
	Formul		5. Social Security Number 6. Se	9x 7. Age (In yrs. last	birthday) If Ur	der 1 Year If Under 24 Hr	s. 8. Date of Birt	1	1000	ace (State or Foreign
	Funeral Director	0	221-54-8966 1	M 2 F 42	Yrs. Mont	hs Days Hours Min	8. Date of Birl (Month, Da	3-62	Counti	(y)(y)
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City. T	own or Location				10	d. Inside City Limits
	/anyl	5	MAN Winn	nico Sai	lisbur	/				1 XYes 2 □ No
	28a-	ect	10e, Street and Number	11 co		Zip Code		10a. Citizen	of What Count	N2
	d within 72 hours after death with the Maryland jene. Ir than "natural", or items 23a or 28a-1 show If a Medical Evaciliar coust ke notified at	Funerai Directo	P.1 BOX 11144			21802		U	S.A	.,,
	ms 2	ner	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was De	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No	- 14. F	Race - America	
٥	after or ite		1 Never Married 2 Married	Armed Forces? 1 □ Yes 25 No If Yes, Give			no nican, etc.,	1	Black, White, e	
3	72 hours after natural, or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1,010	s 2 No Specify:		<i>Sp</i> θ	cify: B	ACK
ה	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra-		6a. Decedent's U (Give kind of	work done during most of we	orking	16b. Kind of	f Business/Indu	ustry
7	within ene. than "	idn	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)		/	VIA	
V	led w tygie her t		17. Father's Name (First, Middle, Last)		VI,	abled 19 Mathada No	ame (First, Middle,	Maidan Sum		
	be filed tal Hyg od othe event,	Be	11	Williams		Davis	. ,	Maiden Sun	- L	1
Š	d Mer nark natic	٦	Herman T 19a. Informant's Name/Relationship (7)	_	10b Mailine Add	ess (Street and Number or F	ed Lec	, Lai	7 1 OE	Control .
<u> </u>	ges 1 and 2 should t of Health and Mer if item 27 ie marks or other traumatic		David I	/- 11	D , D	ess (Street and Number of F	2/ 20	er, City or Tol	on, State, Zip (2009)
<u>တ်</u>	1 and Health em 27 ther t	,	1) 4/Sey Lee W///. 20a. Method of Disposition		e of Disposition	Name of	S Dary 11	20c. Locatio	on - City or Toy	vn. State
פַ	Pages nent of int: if it		Burial 2 Cremation 3	Removal from State	etery, crematory	or other place)	20/05	Blad	21 11) 1GG72
Saltimor	permit. Page: Department of Important: If any injury or		 4 □ Donation 5 □ Other (Specify 21. Signa ure uneral Service Licen 			and Address of Facility	20103	FIAU	25 PI	2/201
g	Depa Impo any i		21. Signature dineral service Electric	- Lh -	R	Sand Address of Acting	and Home.	-9/7/	W. IS. 6.4	11 ct
		1	23a. Part. Enter the disease, or com	pications that caused the death.	Do not enter the	node of dying, such as cardia	ac or respiratory ar			Approximate
			shock, or hear failure. List only immediate Cause (Final	_						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a CHF	0					
	Examiner			PNEUMOI					ŧ	
		ē	Sequentially list conditions, if any, leading to immediate							
	uted Instit	Examiner	Cause. Enter Underlying	M						
	be executed ician and burial-transIt	xa	that initiated events resulting in death) Last	Due to (or as a consequent	ce of):					
9	sicial sicial			d						
P8/P0	ificate g phy as the	edic		v						
ž	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	/ 			23d.	Date of deliver	у
	death e atte	icia	in the past 12 months?	1 Live birth 2 Fetal de. 4 Pregnant at time of death		c pregnancy (specify)			Month E	Day Year
J.	t the by th	hys	9 Unknown	9□ Unknown						
ς Υ	w requires that the deben signed by the should be detached	y P	Part II. Other significant conditions of	•	ng in the underlyi	ng cause given in Part I.	23e. Did to	obacco use c	ontribute to the	cause of death?
ğ	quire an sig	edi	PANHYPOPIT	UITARISM			1 🗆 1	Yes 2□No	3 Proba	bly 4 G Unknown
ပ္သ		piet	HYPOADR	GNALISM			24a. Was	an 24	b. Were autop	sy findings available
VII.а! жесога	siclan: The law r certificate has be irector, page 2 sh	Completed by	ANEMIA					ormed?	death?	
Ø	an: rtifica for, p	0	25. Was case referred to medical			26. Place of De	eath (Check only o			
	Physiclan: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Impatient 2 ☐ ER	/Outpatient 3	DOA Other: 4 Nursing	Home 5 Resid	dence 6 🗆	Other (Specify))
10 [ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury at Work?	28d. Describe I			
0	ath. pr: Af	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1	M	1 ☐ Yes 2 ☐ No				
DIVISION	al or Attending F s after death. i Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fac	ctory, office	28f. Location (S City or Tox	Street and Nu wn, State)	mber or Rural	Route Number,
ב	rs aft ai Di	Cer					W.			
	tospi t hou uner		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled	dge, death occur	red at the time, date and plac	e, and due to the	cause(s) and	manner as sta	ted. the cause(s)
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	Medicai	one)	and manner stated.	- I i i i i i i i i i i i i i i i i i i					
	To Yeitl	~	29b. Signature and title of certifier	· D .		29c. License number D 57952		_	ned (Month, D	ay, rear)
	011	11.	- JNXI EN	· / ·		-01/12	_	- / -	7/ 4)	

DHMH 17 Rev 1/2001

State

Registrar

APR 2 7 2005 Man & Spark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bebulal Las 106 Hulford ST. # 5643 Salisbury MD 21804

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		Please Type or Print in Black Indel		-	•	
			ment of Health and Micate of Death		iene 005	15823
Physici	an	1. Decedent's Name (First, Middle, Last) Marion Jacqueline Adams		2. Date of Death	Day Yeer	3. Time of Death
/Medie Examir			. City, Town, or Location of Death	May 7,	2005 4c. County of Death	8:50 PM
Exami	iei	Carroll County General Hospital				11
Funeral		1 N SETE CA	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Oct. 8	Year) 9. Birthpl	
Director		220 – 36 – 5142		UCE. 0	,1940 Mar	yland
anylan show	7	10a. State 10b. County 10c. City, Town or Location			11	Od. Inside City Limits
the Mi	ecto		esville Of. Zip Code	10	Og. Citizen of What Coun	1 Tes 2 No
hours after death with the Maryland hours after death with the Maryland tural; or Items 23a or 28a-f show at Experiment must be rediffed at	Funeral Director	6350 Piney Ridge Drive	21784		USA	шут
ems 2	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 15. Was Decedent Ever in U.S. 17. Was Armed Forces?	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Yes 2X No Specify:	,	Canaltu	ack
2 hour		15. Decedent's Education 16a. Decedent's	s Usual Occupation		16b. Kind of Business/Ind	
be filed within 72 tal Hygiene. d other than "na! event, the Medic	Completed	Flementary/Secondary (0-12) College (1-4or 5-) life. DO N	l of work done during most of worki NOT use retired)	ng	Springfie	ld State
led wi tygien her th		2 years C	Counselor 18. Mother's Name		Hospital	
d be fi	To Be	William Pugh			rborough	
2 should be filed within and Mental Hygiene. is marked other than reumetic event, the Mental	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	ddress (Street and Number or Rura	l Route Number,	City or Town, State, Zip	
and and salth n 27		Valerie M. Tyner/ Daughter 2104 F				
Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemeraty, cremator	ry or other place)		20c. Location · City or To	
			n Cemetery 5/1 me and Address of Facility Cha			
permit. Departr Imports any inji		Lever Harris 524	10 Reisterstow	n Road	Baltimor:	e, MD2121
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	Namy HARE.	37		Onset and Death
Examiner		Due to (or as a construence of):	Pastreetic C	Ascen		
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4.			
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	ā					
leath certificate be attending physic	Medic	d				
ath cer tendir	lan/N		opic pregnancy		23d. Date of delive	ry Day Year
The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	1 Yes 2 Oro 4 Pregnant at time of death 5 Oth 9 Unknown	ner (specify)		Wichian	Day Toal
res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
w require been sig should b				1 ☐ Ye	s 25No 3 Prob	ably 4 Unknown
a law r has be e 2 sh	Completed			24a. Was ar autopsy	prior to con	osy findings available inpletion of cause of
icien: The la certificate has	e Cor	25. Was case referred to medical			No 1 ☐ Yes	2 No
nysicien: nis certifica i director,	0	examiner?	26. Place of Death Other: 4 Nursing Hor		nce 6 Other (Specify	•)
ng PI	on: T	27. Manner of Death 28a. Dafe of Injury (Month, Day Year) 28b. Time of Injury			w injury occurred	
ttendi death. stor: A	icat	2 Accident investigation 3 Suicide 6 Could not be		28f Location (Str	eet and Number or Rura	Pouto Number
after after Direction by	Certification:	determined determined	ractory, office	City or Town		Houle Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it.		29a. Certifier (Check only (Check only Medicel Examiner: On the basis of examination and/or investig	curred at the time, date and place, a	and due to the ca	use(s) and manner as st	ated.
thin 24 thin 24 the F mplete	Medical	one) and manner stated.				
F 3 F 3		M m	D 003772	8	5-9.05	, , , , , , , , , , , , , , , , , , , ,
1/12		30. Nam and arress of person who completed cause of death (Item 23a) (Type, Print 21/6) 31. Date filed (Month, Day, Year) MAY 1 1 2005	"A WATTHE	I Wear	t WS	mesty m
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Moss		cnst
Registi	ar	MAY 1 1 2005 Keen & An	and the same of th			
UMU 17 Day 1/2	001					

			1 - For Amend Item Registrar	State of Mi	arylang	843.90 Ce	71110 rtificat	jedh e of	leaith and Death	i Mentai Hy	giene Reg. Ne	2005	15821
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Do Month	Da	y Year	3. Time of Death
	/Media	al	Loyd Ear1 Ak 4a. Facility Name (If not institution, give				4h Cihr	Town o	r Location of De	April		2005 County of Death	5:48 A ^M
1	Examir	ier	Washington Adven		oital				Park	alli		lontgomer	
	Funeral		5. Social Security Number 6. Sec			st birthday)	If Under Months		If Under 24 H	n. (Month. D.	rth av. Year		place (State or Foreign intry)
	Director		577 62 7087 XX	M 2□F	58	Yrs.				May 28	, 19	46 West	. Virginia
	yland 10w		10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside City Limits
	e-fst	ctor	Maryland Prince Ge	orge's		Upper	Mar1	boro)				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	mes Stree			10f. Zip	Code	00770		•	tizen of What Cou	•
	eath v	Funeral	11. Marital Status	12. Was Decedent		13	Was Decer	dent of H	20772	/Specify Ves or N		United S	
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exartil wir must be redilled at	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 27 H			_			(Specify Yes or Nearto Rican, etc.)		Black, White	
5-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			1 🗌 Yes	<u>₩</u> XN0	Specify:			Specify: Wh	ite
15-	in 72 in 72 in at	Completed	15. Decedent's Edu (Specify only highest grade	completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occup rk done d se retired	ation during most of и f)	vorking	16b. K	(ind of Business/Ir	ndustry
2121	d with giene.	ome	Elementary/Secondary (0-12)	College (1-4or 5	5+)	_	urity					Vario	us
pu	al Hyg	BeC	17. Father's Name (First, Middle, Last)							ame (First, Middle		n Sumame)	
y la	Meni Meni Marke Marke	2	Willard E. A							che Mae			
Maryland	d 2 st th and t7 is n treum		19a. Informant's Name/Relationship (Ty Carolyn Sandros				-			Rural Route Numb Upper M	-		o Code) 20772
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinating the notified at once.		20a. Method of Disposition		20b. Pla				May 2,			ocation - City or T	
Ē			XXBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ch	arles	Memo	rial	Garden	S	Leo	nardtown	, Maryland
Baltimore,	permit. Departr Importe any inju		21. Signature of Funeral Service License	= Mo/4	122					ee Funera Road, Cl:			. 6633 01d 735
			23a Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused e cause on each lin	the death.	Do not ent	er the mod	e of dyin	g, such as card	ac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Respir		ry 1	bul	3111					Onset and Death
1	/Medical Examiner			Due to (or as				n A	land	•			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): PARALLY CAUSE (DISEASE OF INJURY)											
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Pareu Due to (or as	mo	nia	Hy	pi	mua				
8760,	ate be executed hysicien and the burial-transit	al Ex	resulting in deathy cast	4 4			. (<i>)</i>					
687	ficate g phys	edlcal		. Sleep	2 H	NEC							
Вох	requires that the death certific een signed by the attending p hould be detached for use as i	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome 1 □ Live birth			Ectopic pr	eanancu				23d. Date of deliv	ery
O. B	at the deat by the att tached for	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (sp					Month	Day Year
Φ.	that the	Phy	Part II. Other significant conditions cor	tributing to death b	ut not resul	ting in the w	nderlying c	alisa divi	en in Part I	23a. Did :	obacco	use contribute to t	he cause of death?
Vital Records,	luires thai n signed t	d by					,	3				777	pably 4 Dunknown
000	S S S	plete								24a. Was		24b. Were auto	ppsy findings available
- Re	9 2 9	Completed								auto perfo 1 ☐ Yes	psy ormed? XX X No	prior to co death?	mpletion of cause of 2 No
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?							eath (Check only	one)		
of	Phys this ral dii	T.	1 ☐ Yes 2 🗓 Xo	ospital: 1 X X npatie 28a. Date of Inju-		R/Outpatien		8c. Injury		Home 5 Resi			(y)
lon	Attending Phyrdeath. sctor: After thi	atlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury	М	Worl	k? Yes 2 □ No	200. 20001120	now inju	ry occarred	
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At hon	ne, farm, str	eet, factory	, office		28f. Location (City or To	Street an	nd Number or Run	al Route Number,
	Hospitel or Atteno 24 hours after death Funerel Director: tely filled in by the			4									
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical	29a. Certifier	ician: To the best of ner: On the basis of and manner sta	i examinatio	ledge, death on and/or in	occurred a vestigation,	at the tim in my or	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s)) and manner as s d place, and due to	tated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier				290	License	number			te signed (Month, /29/05	Day, Year)
73	,		horthorne	Kroners	se	00-1/7		00	60443		4/0	28/05	
	T		30 Name and address of person who of Nathalie J. Narci		,			alcon	na Park	MD 2001	2	f	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	or's Sign	and I	1 و ۱۰۰۰	u.vOli	uo Idik,	TID 2091	4		
	Registr	ar	MAY 1 1 2005	en v	1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dat **Physician** 1600 Roberta Abraham 8 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Hospital Center Westminster, Instantian Menths Days Hours Min. 8. Date of Birth (Month, Day, Year) 8 - 20 - 1920 Carroll Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20F Months 220-22-1793 Yrs. Director South Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28a-f show eny injury or other treumatic event, If a Medical Exactivation to other treumatic event, If a Medical Exactivation 1 ☐ Yes X X No Director Maryland Carroll n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Myrtle Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ X□XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marlon Tindal Mamie Tindal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Abraham Jr./Son 1001 Myrtle Drive, Eldersburg, Md 21784 20b. Place of Disposition (Name of 20a. Method of Disposition Ar butus siematory or other place 5-16-2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus, Md ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wylie F/H P.A. of Balto. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, Md 2113 28a Part 1. Enter the disease, or demotivations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1rrhosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No autopsy performed? 1 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only опе) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 1 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Carroll Hospital Center, Giangeruso, MD 31. Date filed (Month, Day, Year) State Registrar MAY 1 1 2005

			1 - For State Ragistrar		ryland / Depa <i>Cei</i>	artment of H rtificate of I		, ,	ene g. No. 2 () ()	5 15926
	Physici /Medi		1. Decedent's Name (First, Middle, L. JOSEPH	B.	BOR	-		2. Date of Death Month M ft	Day Yea	5 11.43 AM
	Examir	ner		PITAL CET	ITER (In yrs. last birthday)	_	Location of Death		4c. County of De	A
	Funeral Director			12 M 2□F	78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV . 17,	71926 M	Birthplace (State or Foreign Country aryland
	the Marylan 28a-f show	ctor	Maryland Anne	Arundel	10c. City, Town or Lo Brook	_{loation} 1yn Park				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th	al Directo	10e. Street and Number 317 Camrose	Avenue		10f. Zip Code	.225	10	g. Citizen of What U.S	
980	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event. Its Medical Examiner matter be recitived at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 III Yes 2 □ No If Yes, Give Year or Dates:	. 1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 12 No	ispanic Origin? (Spender, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	me <i>r</i> ican India <i>n,</i> hite, etc. White
Maryland 21215-0036	d within 72 he piene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired erintende	during most of worki 1)	ng	Oomino Su	,
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			19a. Informant's Name/Relationship Lorraine J. Bork				an <i>d Number or Rura</i> Avenue, Bi			, <i>Zip Code)</i> yland 21225
Baltimore,	of of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			natory or other place	Park 05-11	11	c. Location - City of	
Balti	perriit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lice	Samme	M) 222 M	Name and Address CCully-Po 237 East	ss of Facility Lyniak Fu Patapsco	neral Ho Avenue,	me P.A. Baltimore	
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8760,	ate be executed hysician and the burial-transit	dical Examine	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):					
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0	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions			derlying cause give	en in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
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Divi	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune		4 Homicide determined	building, etc.				City or Town, S	State)	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1	nysician: To the best of minar: On the basis of e and manner state	xamination and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place, and du	e to the cause(s)
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1	X1			00CA, 30	ol south	Print)	CER STA	ZEET BA	LTIMOR	E MD 21225
25.	Sta Registr	4.	31. Date filed (Month, Day, Year)	32. Registrar	Signature	boarde				

	•	1 - For State Registrar	State of Maryland /	Department of Health and I Certificate of Death	Mental Hygie Reg.	000 00
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Examin Funeral Director	er	423-50-9203	ins Hospital	4b. City, Town, or Location of Death Continued	8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign Country) Alabama
Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Arus		wn or Location urel		10d. Inside City Limit
ges 1 and 2 should be filed within 72 hours alter death with the Maryland it of Health and Mental Hygiene. It is death and Mental Hygiene. Or them 271s marked other than "naturel; or them 271s marked other than "naturel; or other treumatic event, the Medical Evanir or must be retified.	by Funeral Dire	10e. Street and Number 220 Cherry Hill 1 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:	10f. Zip Code 20724 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		USA 14. Race - American Indian, Black, White, etc. Specify: White
I within 72 hou iene. r than "nature tha Medical E	Completed	(Specify only highest gra	ucation de completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired) KECUTIVE ASSISTANT	rking	anufacturing Co.
should be filed ind Mental Hygis i marked other umatic event, L	To Be C	17. Father's Name (First, Middle, Last) Henry Walton Pear 19a. Informant's Name/Relationship (7)	cson		me (First, Middle, Mai Causey	den Sumame)
ss 1 and 2 si of Health and Item 27 is r		Bowling G. Buffor	rd/ Husband 22	20 Cherry Hill Lane, of Disposition (Name of ery, crematory or other place)	Laurel, MI	
permit. Pages Department of t Importent: If Ite any injury or of		1 Burial 2 Cremation 300 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Lawre		onaldson I	
death certificate be executed Medical Example and many physician and for use as the burial transit	ilcal Examiner	shock, or helant failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undervin. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	e of):		Approximate Interval Between Onset and Death I HREE YEA
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i Sign	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)		City or Town, S	
1447	edical	(Check only one)	iner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	urred at the time, date	and place, and due to the cause(s)
within 24 hours a To the Funerel (completely tilled	M	29b. Signature and title of certifier	, 1	29c. License number RES - OC		Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OS OS Physician FEA-BOLLING 7-47 PM /Medical MAY 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 900D SAILL ARTTAN NIA HUSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 21 F 216-44.0184 3 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f ehoweny injury or other treumatic event. The Medical Experiment 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Completed by Funeral Director 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5710 21239 Beachdale U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 13 Th Hone Homemaker NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORROW, SR EVELYN HEARY Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benehdale Ave, Balto. No BOILING 21239 WILLIAM 5710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DAYVIEW Cremetory * 4 ☐ Donation 5 ☐ Other (Specify) Bu Ito. MD 110/05 22. Name and Address of Facility STELLA Fune HARTIEY MillER - STELLA Fune 7527 has Ford RD. Balto. signature of Funeral Service Licensee FUNERAL HOME CITTO 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician ACUTE RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The faw requires that the death certificate be executed PLEURAL EFFUSION and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Impatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) M'D MAY, 08, 2005 automo RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar SHILPA

31. Date filed (Month, Day,

CHAITONDE

5601

OCH RAVEN BLVD

BALTIMORE

NID 21239

		1	For State	State	of Marylan		irtment of H	lealth and M Death		200	15	15829
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	Physicia				ley Ann	Rowen			Month May 0	7, 2005	Year	11:57 P ^M
	/Medic Examin		4a. Facility Name (If not institution			2011011	4b. City, Town, or	Location of Death	ridjo	4c. County		
	Examin	- 1	Laurel Regiona	al Hospit	al		Laurel			Princ	e Ge	orge
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birth	place (State or Foreign
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-	2 .)	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
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Maryland 21215-0036	ntal hed of	Be c	Woodrow Crawfo					Pauline			,	
$\frac{3}{2}$	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or flems 23a or 28e-f show aumetic event, the Medical Exart and the motified at	2	19a. Informant's Name/Relations			19b. Mailin	ng Address (Street	and Number or Rur		r, City or Town	, State, Zi	p Code)
_	and 2 s ealth an n 27 is ter trau		Linda Siders	/sister	•	819 4	th Stree	t, Laurel	, Maryl	and 207	707	
ō,	s 1 ar f Hea f Hea item 3	1	20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of natory or other place		Date	20c. Location		own, State
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumetic evonce.		21. Signature of Funeral Servic	-		22 D	. Name and Addre	ss of Facility Funeral	Home. P.	. A .		
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Division of Vital	Phys rthis ral di	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Da	te of Injury	ER/Outpatier 28b. Time o	f 28c. Injur	ry at	28d. Describe h			ny)
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	al or A	Certification:	4 Homicide	bul	ilding, etc. (Specii	19)			- Only 0, 100	on, Otalo)		
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	with To	~	29b. Signature and title of certifie				290. Licens	45011	1 1	M A	à l'i	2005
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	W		30. Name and address of person	MARTI	ruse or death iter	23a) (Type,	343 04	torry	Ltne	40/	w	M 20707
	Sta		31. Date filed (Month, Day, Year,	32	Registrar's Sign	ature						
	Regist	ar	MAY 1 1	2005	Leve D	400	40/					

DHMH 17 Rev 1/2001

			1 - For State Registrar			artment of rtificate of		Mental Hygie	2005	15830
	Physici	an	1. Decedent's Name <i>(First, Middle,</i> Nigel	•	cholson	D	25200		Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution,				or Location of De		05	9:55 P M
	Examir	ier	University of Ma			Baltime		atn	4c. County of Deatl	n
	Funeral Director				ge (In yrs. last birthday) 21 Yrs.		If Under 24 Hi		9. Birtl (Co.	nplace (State or Foreign untry) PA
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-1 sh	tor	MD NA		Baltimo	re				1√Xes 2□No
	th the	Jirec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	ath w	rai	1635 Lorman				1217		U.S.A.	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. Ifem 27 Is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Everther must be notified at	by Funeral Director	11. Marital Status 1 X X ever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cub		(Specify Yes or No- arto Rican, etc.)	14. Race - Amer Black, White Specify:	rican Indian, e, etc. Black
21215-0036	72 hor	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occu	pation	16b	. Kind of Business/l	
21	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	kind of work done DO NOT use retire	ed)	orking		
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me		9th grade 17. Father's Name (First, Middle, L	na na		Unempl		Cina Middle Mari	Unempl	.oyed
Maryland	ould be fi Mental H arked ot atic ever	Be	Robert Allen	ist)				ame (First, Middle, Maid		
Ž	should Ind Meni	ဥ	19a. Informant's Name/Relationshi	o (Tvoe, Print)	19b. Maili	na Address (Stree		nne Mitche Rural Route Number, Cit		in Code)
∑	and 2 s ealth ar n 27 is ier trau		_Gladys Hall-N					Baltimore,		215
Je,	is 1 and 2 of Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo				Location - City or 1	
E	Pages nent of int: If it		1 ☐ Burial 2√ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State ocify)	Metro C	-	- / 1	1/2005 F	Baltimor	e. Md
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		21. Sign John of Funeral Service Li		22 M	Name and Addr	ess of Facility H West	e, Baltimo		21215
in the second	Pnysician /Medical Examiner	er	23a. Part. Effer the disease, or c shock, others failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	a consequence of:		ing, such as cardi	U		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and ad for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
O	res that the death certification of the attending place detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	⊒Ectopic pregnanc] Other (s <i>pecify)</i> _	у		23d. Date of deliv Month	very Day Year
rds, P	The taw requires that the tee has been signed by though 2 should be detached.	by	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.	- 1		the cause of death?
al Records,		Completed						24a. Was an autopsy performed' 1 Yes 2	prior to co	opsy findings available ompletion of cause of
Vital	Physician: this certificanal director, I	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No	Hospital: 1 ☐ Inpatie	int 2X ER/Outpatier	. 2020. 0#		eath (Check only one)	0.500	
of		i —	27. Manner of Death	28a. Date of Injur	ry 28b. Time of	28c. Inju	ry at	Home 5 Residence		ity)
ion	Attending Is death.	atio	1 □Natural 5 □ Pending 2 □ Accident investiga	tion 5/3/6		Wo M 1 □	rk? Yes 2.75%No	Decemed	shot se	elf
Division	i Pite o	Certification:	3 Suicide 6 □ Could no 4 □ Homicide determin	28e. Place of Inju building, etc	ury - At home, farm, str c. (Specify) home			Baltimon,	MD 2121	orman court
	Hospital Z4 hours a Funeral I	edical	(Check only 2 X Medical E)	Physicien: To the best of aminer: On the basis of	examination and/or in	occurred at the til	me, date and place	ce, and due to the cause curred at the time, date a	(s) and manner as a	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta	ated.	29c. Licens			Date signed (Month,	
}	F 3 F 8		· XIDIA	~ //\		OCME				July, rodi/
			30. Name and address of person with	no completed cause of d	eath (Item 23a) (Type			May	4, 2005	
			30. Name and address of person with S. R. H.)GAN	7	111 Per	nn Street	t Baltimor	e, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Dec. (Aur)	1 20 132. Regist	s Signature	Sparte				

1 - For State Registrar	
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15021

Physician
/Medical
Examiner

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attanding Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit within 24 hours after death. To the Funeral Director: After this

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	ate of Marylan	Cer	tificate	of Deal	th		eg. No.	UÜ	100	31
sici	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month May 8,		Year	3. Time of	
dic		Howard T. Bopp			41. 03. 7			May 8,			5:00	рм
min	er	4a. Facility Name (If not institution, give street 1024 Beechfield				own, or Location timore	on of Death			ty of Death		
ral or		5. Social Security Number 217–22–8413 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under	Year If Und Days Hour	der 24 Hrs.	8. Date of Birth (Month, Day	Year) 1928		place (State of ntry) vland	r Foreign
		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Loc	cation						10d, Inside Cit	ty Limite
	ector	Maryland Baltimore	100.0,		imore						1 🗌 Yes	´
	Funeral Director	10e. Street and Number 1024 Beechfield Aven				21229			Og. Citizen of	d Sta	ites	
	þ	1 Never Married 2 Married 1	/as Decedent Ever in U.S med Forces? ሺYes 2⊡No Yes, Give ear or Dates:		Vas Decede Yes, speci			ecify Yes or No- Rican, etc.)		ace - Americack, White,		
	eted	15. Decedent's Education (Specify only highest grade con		16a. Deced	ent's Usual kind of work	Occupation done during n	nost of work	ing	16b. Kind of	Business/In	dustry	
	mple		ollege (1-4or 5+)			seman			Liquor	Dist	ributor	
	Be Completed	17. Father's Name (First, Middle, Last) August Bopp	-		201.04			e (First, Middle, I	Maiden Suma			
	2	19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailin	g Address	Street and Nur	mber or Rura	al Route Number	, City or Town	n, State,_Zip	Code)	
		Rose Bopp / Wife		1024	Beech	field A	lvenue	, Baltin	more, M	iaryla	ınd 212	29
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	(al from State	ace of Dispos ometery, crem e View	natory or oth	ner place)	5/12		^{20c.} Location Sykesvi	,	own, State Maryla	nd
9300		21. Signature of Funeral Service Licensee	Sind			Address of Fa	11 0	bbard . Balt	Funer imore	al Ho	ome, 1	inc.
an al er		23a. Part1. Ent-v the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ns that caused the death use on each line. Due to (or as a consequ	Do not ente	or the mode	of dying, such	as cardiac d		ost,		Approximate Interval Betwoonset and D	veen
	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequ			gam	mif	3			- 19	~> .
	Σ	in the past 12 months?	yes, outcome of pregnar □Live birth 2 □Fetal □Pregnant at time of de □Unknown	death 3 🗌	Ectopic pre Other (spe					ate of delive	_	ear
	d by Ph	Part II. Other significant conditions contribu	ting to death but not resu	lting in the un	derlying ca	use given in Pa	art I.		oacco use con es 2 □ No	ntribute to th	he cause of de	eath? nknown
,	Completed by Physician/							24a. Was a autops perform	y	. Were auto prior to co death?	ipsy findings a mpletion of ca	vailable use of
	BeC	25. Was case referred to medical examiner?				26. PI	ace of Death	(Check only on	1			
	ှင	1 ☐ Yes 250No Hospii	1 Inpatient 2 1	ER/Outpatient				me 5 eside			y)	
	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury at Work? 1 ☐ Yes 2		28d. Describe ho	ow injury occu	irred		
	edical Certification;	3 Suicide 6 Could not be determined 28	e. Place of Injury - At hos building, etc. (Specify	me, farm, stre)	et, factory,	office		28f. Location (Si City or Town	reet and Num n, State)	ber or Rura	ul Route Numb	per,
	edical (29a. Certifier 15 Certifying Physician (Check only one) 2 Medical Examiner:										
	Ň	29b. Signature and little of certifier.			29c.	License number		2	9d. Date sign			
\int	1	Jul Knot	tod source of death (trâm	220\ (Tr	Dei-at	D30	185				2005	
		30. Name and address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address of person who complete the whole who was address.		Frede	erich		Suste	210, (Puter	sville	(MI) -	2228
Sta istr		MAY 1 1 2005		Ure A	herte							
1/20	001		•	-								

Registrar

Harry M. Berwager 05-03241 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Registrar	ate of Maryland / D		nent of He cate of E			Reg. N	21115	15832
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Month		ay Year	3. Time of Death
	/Medic		Harry Melvin Berwga					May	9, 20	005	6:38 P M
	Examin	er	4a. Facility Name (If not institution, give street	and number)			Location of Dea	ith	4	c. County of Deat	h
			2807 Berwick Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birti		altimor	'C If Under 24 Hr	S Q Data	4 Dieth	O Died	h-la (Ct-1 , 5
	Funeral Director		213–30–3314 Usual Residence of Decedent			nths Days	Hours Mir	Dec.	of Birth h. Day, Year 4,1933	mary.	hplace (State or Foreign untry) Land
	yland		10a. State 10b. County	10c. City, Town	or Location	1					10d. Inside City Limits
	Mar B-f-t	ioi	Maryland	Baltimo	re						Y☐Yes 2☐No
	th the	Funeral Directo	10e. Street and Number		10	f. Zip Code			10g. C	itizen of What Co	untry?
	23a	ai	2807 Berwick Avenue			21234			l	JSA	
	teme term	nue	A	as Decedent Ever in U.S. med Forces?	13. Was D	ecedent of His specify Cuban	panic Origin? (, Mexican, Pue	Specify Yes o	or No-	14. Race - Ame Black, White	
30	s afte	by F	If	YYes 2 ☐ No Yes, Give ear or Dates:		es 2 💢 No	Specify:			Specific	
5-0036	be filed within 72 hours after death with the Maryland all Hyglane. Id lithy yilene. Id other then "natural", or iteme 23a or 28e-f show other then "natural", or iteme 23a or 28e-f show event. I've Medical Evanciaer must be notified at		15. Decedent's Education		Decedent's	Usual Occupa	tion		16h	Kind of Business/	ite
Ç	n n	Completed	(Specify only highest grade com	pleted)	(Give kind o	of work done do OT use retired)	uring most of w	orking			ference Center
717	r the	шо	Elementary/Secondary (0-12)) ege (1-40r 5+)		ative Ass					lth Benefits
<u> </u>	e filed will Hygien other th	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, M			241 251 27 2 3
yland	uld be Aental rked o	To E	Harry F. Beru	ager			Merry	В.	Knight		
Mary	2 should and Mer is marke eumatic		19a. Informant's Name/Relationship (Type, P.	rint) 19b.	Mailing Add	dress (Street ar	nd Number or F	Rural Route N	umber, City	or Town, State, Z	Tip Code)
	is 1 and 2 should of Health and Men item 27 is marke other treumatic		Charles T. Smith / Cousin					town, Pe	nnsylva	ania 1736.	3
aitimore,	ges 1 It of He Iffiter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	20b. Place of cemetery	Disposition , crematory	(Name of or other place)	Date	20c. l	Location - City or	Town, State
Ě	Pages ment of ent: if it ury or o		* 4 □Donation 5 □ Other (Specify)	Hilltop	Servio	æ Comp.	5/13,	/ 05	Тоше	son, Maryla	and
ga	permit. Page Department o Importent: if any injury or once.		21. Signature of Funeral Service Licensee	2/		ne and Address	_	_		York Road	
	20 = 4 O		las fiffe	7 7						7,MJ.21204	Approximate
ı	Physician /Medical Examiner	iner	Sequentially list conditions. b	He to (or as a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence	in C	ardio	vascu	lan 1	Dis	earl	Interval Between Onset and Death
68/60,	death certificate be executed e attending physician and id for use as the burial-transit	edicai Examiner	that initiated events	Due to (or as a consequence o	f):						
O. Box	res that the death certific signed by the attending p I be detached for use as i	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown		pic pregnancy or (specify)				23d. Date of deli Month	very Day Year
S,	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contribut	ing to death but not resulting in	the underly	ing cause give	n in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ğ	w require been sig should b	ed							1 ☐ Yes 2	2 XNo 3 ☐ Pro	obably 4 Dunknown
Š	wa dis	Completed			_				Was an autopsy	24b. Were au	topsy findings available
r	Th ate pag	Соп							performed?	death?	2 No
VII	sicien: T certificat rector, pa	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check o	nly one)		
0	Physician: this certific ral director,	၉	1 XYes 2 No Hospit	1 Inpatient 2 ER/Out		DOA Other	4 Nursing	Home 5□	Residence	6 X Other (Spec	eify) scene
	ding th. After	ation:	2 Accident investigation	a. Date of Injury 28b. Ti (Month, Day Year) In	ime of jury M	28c. Injury Work' 1 🗆 Y	at ? es 2 □ No	28d. Desc	ribe how inj	ury occurred	
DIVISION	in District	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, fan building, etc. (Specify)	m, street, fa	ctory, office			on (Street a r Town, Star		ral Route Number,
	To the Hospitel within 24 hours (To the Funerel completely filled	ledical	(Check only one) 2 X Medicel Exeminer: C	: To the best of my knowledge, in the basis of examination and and manner stated.	death occu Vor investiga	rred at the time ation, in my opi	e, date and place nion, death occ	e, and due to surred at the t	the cause(: ime, date ar	s) and ma <i>n</i> ner as nd place, and due	stated. to the cause(s)
	To the To the complet	X	29b. Signature and title of certifier	\sim \sim		29c. License OCMI				10, 2005	
1	JXX,		30. Name and address of person who completed	ed cause of death (Item 23a) (1 Penn	Street	Balt:		Marylar	
Ì	Sta		31. Date filed (Nanth, Day, Year)	2. Registrar's Signature	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month May 01 2005 Ruth Ledbetter Brown 1:15pm[™] 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bel Air Brightview Assisted Living Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🗙 F 90 10/13/1914 North Carolina 215-22-4875 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Ring Factory Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Years Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rev. John Clarence Ledbetter Edith Limer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Johnson- Daughter 4964 Woodward Gardens, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery 1 4 □ Donation 5 □ Other (Specify) 05/05/05 Havre de Grace, MD 21. Şignature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, ND 21078 V 3a Eart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alshimer's Years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 🗷 Residence 6 □ Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) actoritarion M.D. 10047813 Man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 20 upper Chesapeake Dr. Smite ZII Beldir Mi) 21014 DASHAR KARAKASH 31. Date filed (Month, Day, Year) MAY 1 1 2005 32. Registrar's Signature

State Registrar

Physician

/Medical

Examiner

Funeral

Director

rral', or items 23a or 28a-f ahow L'Examiner mant be notified at

than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008.

Physician

/Medical

Examiner

attending physician and for use as the burial-trar

The law requires that the death certificate be executed

To the Hospitel or Attending Physician:

After this funeral dir

within 24 hours a To the Funeral I

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

by

Completed

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2

Certification:

Medical

Director

Funeral

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Completed

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, Year **Physician** Millard May 2005 Marion Brust 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 40 East South Street Frederick Frederick 5. Social Security Number 214-10-2577 8. Date of Birth (Month, Day, Yo If Under 1 Year | If Under 24 Hrs. | 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1916 Mary Land Days Hours XXM 2 F 88 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick XXYes 2∏No Director 10e. Street and Number 40 East South Street 10f. Zip Code 21701 10g. Citizen of What Country? U.S.A. or itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? YXXYes 2☐ 1942-1945 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreman/Supervisor Cemeterv other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t of Health and Mental John Casper Brust Ruth May Crummitt ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rosalie M. Brust, wife 40 East South Street, Frederick, MD 21701 20b. Place of Disposition (Name of 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 5 Mount Olivet Cemetery permit. Page Department o Important: If any injury or once. May 12, 2005 Frederick, MD ⁴ □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee ²² Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD P M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death Check on one axaminar Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Thomicide filled within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 9, 2005 completed cause of death (Item 23a) (Type, Print) oll House Frederick, MD 21701 80 MO

State Registrar 31. Date filed (Month, Da)

32 Registrar's Signature

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	Funeral Director				e (In yrs. last birth	rs.		lours Min.		y, Year)	O Mou	place (State or Foreign ntry) ソッカル
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	how		10a. State 10b. County		10c. City, Town	or Lo	cation			,		10d. Inside City Limits
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	or 24	Dire	10e. Street and Number				10f. Zip Code				en of What Cou	ntry?
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JO L	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				iatory or other place) Crematory, I	na 5/1	0/05	Ral	timore	Citu
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tha Mente.		21. Signature of Funeral Service Licens		j Doig Vieo		Name and Address of Lhumunek Fu					
ä	Depa Impo any is		Delaction	Kune	Ru	Sc	Lhumunek tu	ineral	Home Inc	2. B	altimore	ims Lane 2, Md 21213
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused	the death. Do no	t ente	er the mode of dying, s	uch as cardia	c or respiratory a	rrest,		Approximate Intervat Between
	Physician		Immediate Cause (Finat disease or condition	MAT		TI	e SYNU	MIAL	CARCI	ALONE	A	onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	770-0	777		, 4 0//		((((((((((
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	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)				Month	Day Year
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of	examination and	death or inv	occurred at the time, o estigation, in my opinio	date and place on, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as solace, and due to	tated. o the cause(s)
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	121		30. Name and address of person who co		eath (Item 23a) (T	ype, I	Print)	- 0		4100	1 0 //	2005 T, Baltimon, M
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	Registr	ar	MAY 1 1 2005	Station	St. Age		V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician /Medical Ronald Louis Brown 2005 9:30 P. May 4, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1,25M 2□ F Days Hours Yrs. Director 50 217-64-0794 11/09/1954 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "netural; or Items 23e or 28e-f show treumetic event, the Madical Exercities regarded or notified at 10d. Inside City Limits 1 Yes 2 No Directo MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2816 Fifth Avenue Funeral 21234 United States 12. Was Decedent Ever in U.S. Armed Forces2-1 ☐ Yes 2 5 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Completed by Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Grocery Stock_Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Thomas Brown Ann Catherine Dignan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: if item 27 is Joseph R. Brown / brother 2416 Harwood Road Parkville, other ! MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State ō May 6 ^ 4 □ Donation 5 □ Other (Specify) 2005 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee M00986 22. Name and Address of Facility ale Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jew C: Physician reparocellular Carcinons /Medical Due to (or as a consequence of): **Examiner** reporting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 30 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 4 Nursing Home 5 Residence 6 ther (Specify) NO 5 (۵ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After the 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours Actifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) harles St Baltimore My 21204 ronces

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** M4-24-2005 HARRY **BROWN** 4:39am /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth 12011 924 9. Birthplace (State or Foreign Washington, DC 16 M 2 □ F 220-12-3719 80 Director Vre Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 7 le marked other then "naturel", or items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 TYes 2 No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4601 Martin Luther King Ave. SW 20032 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 24⊡kNo Specify. 3 Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter Self- Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Brown Sr. Rosell Bassel 19a. Informant's Name/Relationship (*Type, Print)* Vonciel Foggie /Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 6523 Hilmar Dr. District Heights, MD 20747 ages 1 and 2 sint of Health and : If item 27 len 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 ☐ Burial 2 Tremation 3 ☐ Removal from State ō permit. Page Department of Importent: If eny injury or Riverdale Park Cre. Riverdale, MD `4 ☐ Donation 5 ☐ Other (Specify) 4/28/05 21. Signature of Funeral Service. 22. Austinaryster Funeral Home 3821 14th St. NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cadse (Final disease or condition resulting in death) Onset and Death **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner BILATERAL PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit ADVANCED COPD Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 * Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Division of Vital 1 Yes 2 No 1 Yes 2□ No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 _npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dir 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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	Examii Funeral	ner	4a. Facility Name (If not institution, give street and num Southern Maryland Hospit 5. Social Security Number 6. Sex				8 Date of Birth	4c. County of Death Prince G	eorges
	Director		579-14-8465 1 M 2 D F Usual Residence of Decedent	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	30,1919 Wa	place (State or Foreign intry) ashington,[
	e Marylan 3a-1 show Illied al	ctor	10a. State 10b. County	10c. City, Town or Li Washing	gton, DC				10d. Inside City Limits 1 ★ Yes 2 No
	th with th	Funeral Director	10e. Street and Number 1659 Fort Davis Place S		10f. Zip Code 20020		1	og. Citizen of What Cou United St	•
5-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28a-1 show offical Examiner must be notified at	b	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Note of Divorced 12. Was Dece Armed For 1 Yes, Giv Year or Day	2 1 No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe i, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Amen Black, White, Specify:	can Indian, etc.
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	s 1 and 2 sho of Health and item 27 is ma other treum		19a. Informant's Name/Relationship (Type, Print) Waynette W. Threatt (Gre	eat Niece) 16	559 Fort Da	avis Pl.	SE Wash	City or Town, State, Zipington, DC	20020
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natur any njury or other treumetic event, If a Madical DDEs.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	20b. Place of Dispo cemetery, crea Harmony	osition (Name of matory or other place, Memorial I 2. Name and Address AUSTIN RO	Park 4/2	ate 2 2/05	Landover,	own, State
68760,	ate be executed / Medical and / Medical and / Medical transit the burial-fransit / Medical / Med	Aedical Examiner	d		3821 14th	o St. NW	Washing	ton DC 200	Approximate, Interval Between Oysel and Ireath
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Divi	o Dir		4 Homicide determined 286. Place of buildin	of Injury - At home, farm, str g, etc. <i>(Specify)</i>			City or Town,		
	he Hospitel in 24 hours a he Funerel I pletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the late of the l	sis of examination and/or in	occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	nd due to the ca d at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the within 2 To the complete	Σ/	29b. Signature and title of certifier	D Alley	29c. License r	2453	5 29	d. Date signed (Month, 1	Day, Year)
1	V('			0/01d Branch		e 101 Cl	inton, M	ID 20735	
DH	Sta Registr MH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature ORIGINA	Loute		- 3u - 1 0	11.5	

T			1 - For State Unpend Item	State of Maryl 23a,27,28a-f	land/Dep per ne e	artment of H FillCate of 1	ealth and M D @a trtas	lental Hygier Reg. N	e 005	15839
	Physici	ian	1. Decedent's Name (First, Middle, Las Teresa Elat	,	Bettis				ay Year	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	May 9, 200	J5 Ic. County of De	3:00 P M
	LXGIIII	Ų	619 Crucible Cour	t		Millersv		Aı	nne Arur	ndel
	Funeral Director		5. Social Security Number 6. S 311–68–4863		yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		irthplace (State or Foreign Country)
	ъ		Usual Residence of Decedent					Sept.30,	1957 O	clahoma
	larylar show	Į.	10a. State 10b. County Maryland Anne An	1	: City, Town or Le	rsville				10d. Inside City Limits 1 ☐ Yes 2X No
	28a-f	Director	10e. Street and Number	dider		10f. Zip Code		10a. C	Citizen of What C	
	th with	al DI	619 Crucible Court	t .		21108			ted Stat	,
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumetic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
2-0	72 hou natura iical E	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Busines	
21215-0036	d within giene. ar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired epartment)	ing	Retail	Sales
Maryland	d be filed ntal Hygid ad othar s evant, II	Be	17. Father's Name (First, Middle, Last) Bernard	Inhana				e (First, Middle, Maide		
aryl	should nd Men marka umatic	70	19a. Informant's Name/Relationship (7	Johnson Type, Print)	19b. Maili	ng Address (Street a	Susan and Number or Rura	unkı al Route Number, City		Zip Code)
	and 2 salth a n 27 is		Chadwick Isbell,		7870	Pepperbo		asadena, l		
Baltimore,	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	* -	natory or other place Loose F.H.	May 11	1	Location - City o	
Balt	permit. Departr Imports any inju		21. Signature of Fulleral 3, viol Licen	MO1113	11	2. Name and Addres	1191	man Funeral te G. Glen F		
			23a. Part1. Enter the disease, or composhock, or heart failure. List only		death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory arrest,	diffic, 11	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Skelaxin	(Metaxa	lone) int	oxication	<u> </u>	-	Onset and Death
	Examiner		ſ	Due to (or as a con	sequence of):					
	d ii	iner	Sequentially list conditions, if any, leading to immediate caus. Enter Unorthing Cause (Disease or injury	b. Due to (or as a con	sequence of):					
_	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con	sequence of):					
68760,	ficate be executed physician and s the burial-transit	edical E		d.						
_	nificat ng phy as th		IF FEMALE:							
O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
٦,	res that the signed by be detaction	by Ph	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacco	use contribute (to the cause of death?
ords	w require been sig should b							1 ☐ Yes	2 ⊠ No 3□P	robably 4 🗆 Unknown
of Vital Records,	The ate h page	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita	Phyaician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:		04	26. Place of Death	(Check only one)		
	Phys this ral di	.: To	1 A Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of		4 🗀 Narsing Hon	ne 5 Residence 28d. Describe how inju		ecify) scene
Division	Attanding Ph ir death. ector: After th by the funeral	Certification;	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	Found Day Year 5-8-05	7 Found: 2:51	P M 28c. Injury Work		Subject ing	-	rug
ivis	F = -	rtific	3 N Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	eet, factory, office				Pural Royte Number,
Ω	ospital of hours af unaral D		20a Carifier 1 Cartifying Ph	Found: Res	idence		Mi	11ersville	Anne A	rundel Co.,M
	To the Hospital of within 24 hours at To the Funeral D Completely filled in	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exam	ysician: To the best of my iner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my op	e, uate and place, a inion, death occurre	and due to the cause(: ed at the time, date ar	i) and manner a id place, and du	s stated. e to the cause(s)
	To tha He within 24 To tha Fu completed	Me	29b. Signature and Attle of Cartifier	m	1	29c. License	number		ate signed (Mon.	- '
d	- Kour		30. Name and address of person who c	completed cause of death (Item 23a) (Type,	Drint	Street B	Baltimore,		
100	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 2	32. Registrar's Si	ignature					
	Licalon	en e	INW: TT T	AND BELLEVIE	111 19	Des Assessment				

			For State	State of	f Maryland		artment of H				_			
			Registrar	- 43		Cei	lineale of t	Deali		2. Date of De	Reg. No.	905 -	3. Time of	40
	Physici	an	Decedent's Name (First, Middle, Last				D 11		4	Month	Day	Year		Death
	/Medic		Sharon	Α.			Bridges			May	5	2005	3:30	a™
	Examin	er	4a. Facility Name (If not institution, give	e street and nun	nber)		4b. City, Town, or	r Location	n of Death		4c. C	County of Deal	th	
			950 Tioga Lane				Crowns					Anne Ar	undel	
	Funeral		Social Security Number 6. S	ex □M 2[X F	7. Age (In yrs. la.		If Under 1 Year Months Days	If Unde Hours	Min.	B. Date of Bird (Month, Da	y, Year)	Co	hplace (State o ountry)	r Foreign
	Director		212-54-5299	UN ZOL	57	Yrs.				Feb. 2	4,194	48 Was	hingtor	n, DC
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation						10d. Inside Cir	ty Limits
	aryla	-	,	1 1	100. 0.,								1 TYes	
	Ba-f	ctc	MD Anne A	rundel		Crow	msville							
	or 2	Oire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?	
	72 hours after death with the Maryland natural; or items 23e or 28e-f show itsel Examinat court be motified at	Funeral Director	950 Tioga Lane					1032				USA		
	ems	nei	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.S rces?	. 13.	Was Decedent of H If Yes, specify Cuba	lispanic C an, Mexica	origin? (Spec	ify Yes or No ican, etc.)	1.	 Race - Ame Black, Whit 		
9	afte or it	F	1 Never Married 2X Married	1 ☐ Yes If Yes, Giv	2 🕅 No		1 ☐ Yes 2 No					Specify:	White	
8	ours irai',	dby	3 Widowed 4 Divorced	Year or Da	ates:								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
21215-0036	72 h	ete	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual Occup kind of work done	durina mo	ost of working	,	16b. Kin	d of Business	Industry	
2	ithin Ne.	idu	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired	,			ACTT	T-1		
	ed w ygier ver th	Completed	12			vice	Presiden			-		Electr	:1C	
Maryland	d oth	Be	17. Father's Name (First, Middle, Last)					18. Moti	ners Name	First, Middle,	Maiden S	Sumame)		
<u>×</u>	Men Men arke	2	Thomas Jones						ertha					
a	2 shc and ls m		19a. Informant's Name/Relationship (**		19b. Mailir	ng Address (Street	and Num	ber or Rural	Route Numbe	er, City or	Town, State, a	Zip Code)	
	and saith n 27		Ronald W. Bridg	es (Hus			Tioga La	ne, (-				
ore.	of Hiter		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from	200	ice of Dispo metery, crer	sition (Name of matory or other plac	ce)	Da	te	20c. Loc	ation - City or	Town, State	
Ĕ	Pag not: fi		'4 □ Donation 5 □ Other (Specif			o Cre	matory	Ì	5/9/2	005	Ba1t	imore,	MD	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23e or 28a-f show any injury or other treumatic event, the Madical Examinat order to confile and once.		21. Signature of June/21 Service Licer	S88	111		Name and Addre	ss of Fac	ility	D				
00	Departiment Depart		Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD											
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that c	aused the death.					Approximate Interval 8et	e ween			
. E	Physician		Immediate Cause (Final	2		CANC	EB						Onset and I	Death
	/Medical		disease or condition resulting in death)	a	or as a conseque								6 11001	11-2
8	Examiner													
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	t insit	듄	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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8760,	cate be executed physician and the burial-transit	dicai		d										
687	ficate p phy is the	edic		_ u					-		1			
	death certifi e attending id for use as	/W	IF FEMALE: 23b. Was decedent pregnant		come of pregnan						23	3d. Date of de	iverv	
Вох	atter for L	clar	in the past 12 months?		irth 2 Fetal of ant at time of dea		Ectopic pregnancy Other (specify)	Y				Month		/ear
P.O.	the d	iysi	1 □ Yes 2,2 No 9 □ Unknown	9□ Unkn	own									
	law requires that the death certific as been signed by the attending I 2 should be detached for use as	by Physician/M	Part II. Other significant conditions of	ontributing to de	eath but not resul	ting in the u	nderlying cause giv	en in Par	t I.	23e. Did t	obacco us	e contribute to	the cause of d	eath?
Records,	sign d be	d b								X	Yes 2□	No 3□Pr	obably 4 🗀	Jnknown
0	w require been si should I	Completed								040 146-	. 1	Odb Mara s	denni findinan	
ec -	0 4 0	ıμ								24a. Was autor	osy	prior to death?	utopsy findings a completion of ca	ause of
=	Th ate pag	S								1 Yes	2 No	1 🗆 Yes	2 🗆 No	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Managhab			045		ce of Death	Check only o	one)			
of	Physical this call dir	ို	1 ☐ Yes 2 No		-	R/Outpatier		401	Nursing Hom	- 1		Other (Spe	city)	
_		on	27. Manner of Death		of Injury th, Day Year)	28b. Time o Injury	Wor			3d. Describe I	now injury	occurred		
Si.	Attending r death. sctor: After oy the fune	cati	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2						
Division	or At ter d irect irect n by	Certification:	4 Homicide determined	286. Place	of Injury - At honing, etc. (Specify)	ne, farm, sti	reet, factory, office		28	City or To	strөөt and wn, State)	Number or Hi	ural Route Num	ber,
	urs al	ပိ												
	Hosp 4 hou Fune ely fi	Ca	(Check only 2 Medical Example 12	niner: On the b	asis of examination		h occurred at the tire vestigation, in my o)
	To the Hospitet or Attenc within 24 hours after deatt To the Funerel Director: completely filled in by the	Medicai	one)	and man	ner stated.		29c. Licens					signed (Mont		
	5. tilt o	-	29b. Signature and title of certifier) 44- 0	- /	0		-			E/	INE	, =ug, 13a1)	
	-100		1 Hobert	820 M C	den, W	10	130	0 10	<u> </u>		2/6	100		
1	0		30. Name and address of person who	completed caus	se of death (Item	23a) (Type,	Print)	0	1.	- 0.4 - 4	n 1)	LA I		
		,		EN, MO	12002	Ylledic	al Phury	1 Um	napoles	TVId-	214	01		
	Sta		31. Date filed (Month, Day, Year)	05	egistrar's Signati	II O	alles "		4 ′					
	Registi	al	MAY 1 1 20	UJ KA	1000	5								

		101	partment of Health and I <i>ertificate of Death</i>	, ,	giene Reg. No. () () 5	1501.1
		Decedent's Name (First, Middle, Last)	oranouto or boarr	2. Date of Dea	ath	3. Time of Death
Physicia /Medic	_		Burton, Sr.	MAY	2/2005 Yeer	1345 P M
Examin	er	ta. Fecility Name (If not institution, give street and number) 342 MT。 ZION MARLBORO ROAD	4b. City, Town, or Location of Death LOTHIAN	1	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	(Month, Day	r, Year) Cou	place (State or Foreign intry) Shington, DC
/land	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits
h the Maryland r 28a-f show	ctor	MD Anne Arundel Lothia	n			1 ☐ Yes 2 No
or 28	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Cou	ntry?
leath wi	Funeral	342 Marlboro Road 11. Marital Status 12. Was Decedent Ever in U.S.	20711 3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Amer	ican Indian
5-UU36 72 hours after death with the Maryland netural; or Items 23a or 28a-f show alsal Examiner must be notified at	þ	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Novorced Year or Dates: 1956-58	If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes XX No Specify:	o Rican, etc.)	Black, White	
Maryland 21215-UU30 d 2 should be filed within 72 hours all lith and Mental Hygiene. 27 Is marked other than "natural, or rtraumatic event, tra Medical Exert	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wor a. DO NOT use retired)	rking	16b. Kind of Business/Ir	ndustry
d Z1Z1 filed within Hygiene. ther than " int, the Med	Com	12 Нот	ticulturist		Agricultur	:e
be file	Be	17. Father's Name (First, Middle, Last)			Maiden Sumame)	
should should mark marlc	ပ္	John Henry Burton, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. M	Helen ailing Address (Street and Number or Ru	M. Mack		a Code)
Nd 2 salth ar 27 ls r trau	1		1 Fox Hollow Run		•	D C0008)
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If Item: Iny Injury or other		20a Method of Disposition 120b. Place of Di	sposition (Name of crematory or other place)	Date	20c. Location - City or T	own, State
Page ment tant: It inry o		`4 □Donation 5 □ Other (Specify) Metro (rematory 5/5/	2005	Baltimore,	MD
Baltimore, Intervier permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licentee	22. Name and Address of Facility Hardesty Funeral 12 Ridgely Avenu	e, Annap	olis, MD 21	401
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ardiovarcular DES	Air		
Examiner		Due to (or as a consequence of):				
D ≃	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
be executed siclan and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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	ledicai	Q				
necolids, r.o. box of the law requires that the death certificate has been signed by the attending age 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliving Month	rery Day Year
quires that the nation signed by the	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		obacco use contribute to	× 1°
OT VITAI HECORDS, Physicien: The law requires t this certificate has been signe	Completed			24a. Was a autop: perfor	rmed? prior to co	opsy findings available ompletion of cause of
VITAL Pictor. The certificate rector, pag	Bec	25. Was case referred to medical examiner?		ath (Check only or	ne)	
ding June Afte	tion; To	1 Yes 2 No Natural 5 Pending Accident investigation Hospital: 1 Inpatient 2 ER/Outpa 28b. Tim (Month, Day Year) 28b. Tim (Inju 28b. Tim Inju	e of 28c. Injury at	lome 5 Resid	dence 6 Other (Special control of the control of th	SCENE SCENE
in I	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (S City or Tow	Street and Number or Rui vn, State)	al Route Number,
Hospitel 24 hours a Funerel i	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, can and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	and due to the curred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month)	
10	-) M. Z	OCME		MAY 3, 200	15
1011		30. Name and address of pers. who completed cause of death (Item 23a) (Ty JA CK M. JM, M.D.		Baltimo	ore, Marylar	nd 21201
Sta	te	31. Date filed (Month, Day, Year) MAY 1 1 2005 32. Registrar's Signature	and I			

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year GLADY5 BRUENIK 05 06-2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 422 Does Run Road Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 578-05-2649 88 Director 28,1917 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 422 Does Run Road 21550 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2\ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes **XX**No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Proprietor Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Neil McPhaul Maddy Aires 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Moreland (Daughter) 231 Marlboro Road, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 5-12-2005 Lothian, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RUVI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 st autopsy performed? 1 Yes 2 No 1 Yes 2 X40 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ဂ္ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural s after de. ••I Director: Alte 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HZ611 G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eres Dr. 0 69 Walt 1 NO vanie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

05-03092 Aaron Beale UNKNOWN 05-03092 WHW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** $MAY^{hopth}4, 2005$ AARON BEALE 12:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SB I-895 @ mile marker 26 BALTIMORE CO HALETHROPE H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Yes)

Min. SEPT. 20, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 VIRGINIA 7. Age (In yrs. last birthday) **Funeral** 5, 1957 1**⅓**M 2□ F 217 80 1973 47 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or Iteme 23s or 28s-f show the must be notified at 1X Yes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 1631 DARLEY AVE Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced BLACK "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) SANITATION ENGINEER 10th H. C. HOWELL AND SONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P WILLIAM H. BEALE SR. LILLIE MAE SMITH treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tre once. CECELIA PARTEE (daughter) 2714 BAYONNE AVE. BALTIMORE, MARYLAND 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State `4 Donation 5 Dother (Specify) TRINITY CEMETERY MAY 10, 2005 BALTIMORE, MARYLAND 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 21. Signatury of Funeral Service Licensee 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Muttole Injuries **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed ng physician ar as the burial-to Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 1**7** 1/10 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death? 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence XXOther (Specify) SCENE Hospital: 2 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Passenger in No Certification: involvedin a I □ Natural 5 Pending 12:00 PM n 24 hours and the Funerel Director: Af 2 Accident 3 Suicide 1 Yes 2 □ No investigation 4/05 motor velucie collision 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 B I - 895, mile Warter 16 4 Thomicide Interstate Highwai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MAY 5, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) 111 Penn Street Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

MAY 1 1 2005

			Please			Indelible ink. Ensu	•	_	le.
			For State Registrar	State of Ma		partment of Health a certificate of Death	nd Mental Hy	/giene 20	05 15844
	Physici		1. Decedent's Name (First, Middle, Las GEORGE J.	BARROW	1		2. Date of D Month	eath _	Year 2.04 A M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location of		4c. County of	
			STELLA MARIS AT M		ITAL	BALTIMORE			N/A
	Funeral Director		213 20 0090	7. Age	9 (In yrs. last birtho 74 Yrs	Months Days Hours	Min. 8. Date of B (Month, D) 2 / 2	2 / 1931	Birthplace (State or Foreign Country) MARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location			10d. Inside City Limits
	ith the Marylan or 28a-f ehow e notified at	ţ	MD BALTIM	ORE	RASP:	EBURG			1 □ Yes Z No
	th the or 28s	irec	10e. Street and Number			10f. Zip Code	-	10g. Citizen of W	hat Country?
	23a c	ralD	4007 WHITE AV	ENUE APT	A-2	21206		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Itam 27 Is markad othar than "natural", or itema 23a or 28a-f ehow other traumatic event, the Medical Evanthar must be rediffed at	by Funeral Director	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ZYes 2 1 If Yes, Give Year or Dates:	vo	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	in? (Specify Yes or N Puerto Rican, etc.)		- American Indian, , White, etc. WHITE
5-0036	"natural"	ted	15. Decedent's Ed	ducation	16a. De	ecedent's Usual Occupation	of wordsing	16b. Kind of Bus	siness/Industry
5 25	within 7 ene. than "r	Completed	(Specify only highest gra	College (1-4or 5	i+) //ii	live kind of work done during most le. DO NOT use retired)	or working	РОРТ СТ	TY PRESS
G e0 19 e	e filed with al Hygiene. othar thar vant, the N	Co	17. Father's Name (First, Middle, Last)	0		BOOK BINDER	's Name (First, Middle		
ang Co	Mental I Mental I arkad ol atic eva	To Be		RROW			ELIA J. 1		,,
ary Co	2 should be and Mental Is markad raumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and Numbe			State, Zip Code)
	and 2 lealth a m 27 li		F.CATHERINE BA	RROW/SIS		007 WHITE AVE			
Barrow,	m O 1-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery,	isposition (Name of crematory or other place) CREMATORY	Date 5/9/05		City or Town, State
은 불	그 등 문 글		*4 □ Donation 5 □ Other (Specifical Service Licer)	·/_/	PIETRO	22. Name and Address of Facility		BALTIMO	
Pa Ba	permi Depa Impo any is) (Š		1211 CHESACO	CVACH/RU	OSEDALE BALTIMOR	FUNERAL HOME
40	NAME OF		23a. Part1. Ent the distise, or come shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not	enter the mode of dying, such as			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a		wentic c	uncer		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)				
	F 2	e	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of)				
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Ulacase or injury) that initiated events	c					_2
ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of)				
876	cate b	dica		d	···-				
P.O. Box 68760,	Physician: The law requires that the death certificate b this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the b	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Mon	of delivery th Day Year
	s that the ned by a detact	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in th	ne underlying cause given in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
rds	w requires to	ed b					1□	Yes 2□No	3 Probably 4 Unknown
of Vital Records,	The law re ate has bak page 2 sho	omplet					24a. Wa auto pen 1 Yes	formed?	fere autopsy findings available for to completion of cause of eath? ☐ Yes 2☐ No
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				of Death (Check only		
	ding Physician: 'ih. ih. After this certifica funeral director, p	2	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident Investigatio	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		ie of 28c. Injury at		how injury occurre	
Division	Hospital or Attanding 24 hours after death. Funaral Director: Atter tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	OB Diago of Ini	ury - At home, farm c. (Specify)	, street, factory, office	28f. Location	(Street and Number own, State)	r or Rural Route Number,
	e Hospital of 24 hours at B Funaral D etely filled i	edical (29a. Certifier Certifying Pl (Check only one) 2 Medical Example (Check only one)	hysician: To the best miner: On the basis o and manner st	f examination and/	death occurred at the time, date and prinvestigation, in my opinion, deat	d place, and due to the h occurred at the time	e cause(s) and mar o, date and place, a	nner as stated. nd due to the cause(s)
	o the lithin 2 o the loomblet	Me	29b. Signature and title of certifier	and manner st	ared.	29c. License number	T	29d. Date signed	(Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5/9/2005 29b. Signature and title of certifier 29c. License number D40854

State Registrar

mpleted cause of death (Item 23a) (Type, Print)

Paul Pl.

Bultoner 21202

31. Date filed (Month, Day, Year)

MAY 1 1 2005

			ForStete	State of Maryland /	Department of Health and I	Mental Hygien	ne	rolr
			Registrer 1. Decedent's Name (First, Middle, La	ast)	Certificate of Death	Reg. N		3. Time of Death
	Physicia /Medic		Ray Bo	arnett		Month	9 2005 /	11:27 AM
7	Examin		4a. Facility Name (If not institution, gir	//	4b. City, Town, or Location of Deat		c. County of Death	1
				Sex 7. Age (In yrs. last bi			9 Birtholas	e (State or Foreign
	Funeral Director			10 M 2□F 96	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	108 South	Carolina
	and w	Ī	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	on or Location		104	. Inside City Limits
	Maryli -f sho	tor	Maryland NI	1 Ra	Himore			1 Yes 2 No
	th the	Director	10e. Street and Number	1	10f. Zip Code	10g. (Citizen of What Country	?
	ath w		6302 Ira	mor Kd.	21214		USA	
10	rurs after death with the Marylan at', or ttema 23a or 28a-f show Existiliter is ust be motified	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - American Black, White, etc	
033		by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify:		Specify: Bla	cK
21215-0036	n 72 hours "natural" Bulcal Ex	Completed	15. Decedent's E (Specify only highest gr	ducation 16a ade completed)	Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired) Iffe. DO NOT use retired)	rking 16b.	Kind of Business/Indus	stry
212	d within giene. rr then "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	actory Work	er	Factori	/
	be filed stal Hygi of other event, I	Be	17. Father's Name (First, Middle, Las) +	18. Mother's Nar	me (First, Middle, Maid	en Sumame)	
Maryland	should be nd Menta nmarked umetic ev	스	Jasper t 19a. Informa 's Name/Relationship	Type, Print) (niece) 191	D. Mailing Address (Street and Number or Ru	OIR Sunta Number City	OFTZET y or Town, State, Zip Co	ode)
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ore,	0 0		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	. comoto	of Disposition (Name of ary, crematory or other place)	Date 20c.	Location - City or Town	, State
altimore	perrit. Pages Department of importent: If it any njury or o		`4 Donation 5 Other (Spec	ity) Mt. Ho	armony U.M.Church 3/16	12005 C	over, Sout	h Carolina
Ba	permit. Depart Import any nj		21. Signature of Funeral Service Lice	L' Russ	Joseph L. Russ 22.2 W. North Aug	Funeral H	ome P.A.	
			23a. Parri , Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,	ln	pproximate terval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		YOCARDIAL INFAM	RETION		nset and Death
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	- t	ner	Feduration Fit conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence				
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8760,	The law requires that the death certificate be executed to the as been signed by the attending physician and orge 2 should be detached for use as the burial-transit			d.				
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Вох	eath certific attending pl	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death			23d. Date of delivery Month Da	ay Year
P.0.	that the de ed by the detached	hysic	1 Yes 2 No 9 Unknown	9 Unknown	5 Other (specify)			
	res that igned to be deta	by P	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacci	use contribute to the o	
ord	w require been si should t					1 🗆 Yes	2 No 3 Probabl	ly 4 Nonknown
Vital Records,	The law ate has t page 2 s	Completed				24a. Was an autopsy performed?	24b. Were autopsy prior to comple death?	letion of cause of
ta		0	25. Was case referred to medical	1	26. Place of Dea	1 ☐ Yes 2 🛣	No 1 ☐ Yes 2	□ No
of V	S .s .g	To B	examiner? 1 \sum Yes 2 \sum No	Hospital: 1 Inpatient 2 FR/O	utpatient 3 DOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Specify)	
	ding After fune	tlon:	27. Manner of Death 1. Natural 5 Pending investigation	(Month, Day Year)	Time of Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division	i or Attending Phatter death. Director: After the in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be One Blace of Injury Ashama (28f. Location (Street City or Town, Sta	and Number or Rural R	oute Number,
Ö	urs afte							
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	(Check only 2 Medicel Exa	iminer: On the basis of examination a	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	irred at the time, date a	and place, and due to the	e cause(s)
		Ae Ae	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day	y, Year)
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2	To the within To the comple	4	30. Name and address of person who STEPHEN (2.	completed cause of death (Item 23a)	O. D. 4365. (Type, Print) 5601 LOCH () 1396 TIME	RAVEN 1	BULLVARY 11239	5
2	Sta Registr	ate	30. Name and address of person who STETHEN (g. 31. Date filed (Month, Day, Year)	o completed cause of death (Item 23a) HONTZCANM 32. Regisfar's Signature	29c. License number D 4365 (Type, Print) 5601 Loch B ANTINI B. Apple	S MI RAVEN I REE, MID	AY 9 20 Beween ARI 21239	3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 7:32 AM OWN 05-05 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memoria lnion 9 Birthplace (State or Foreign Maryland **Funeral** Days Min. Months Hours 1□M 2XF Director Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Iteme 23a or 28e-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then " Elementary/Secondary (0-12) College (1-4or 5+) Sekeeper Hygie other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be nent of Health and Mental is not: If Item 27 is marked o . Informant's Name/Relationship (Ty e, Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. atto Md, 21213 or other 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory 1 X Burial 2 ☐ Cremation 3 Removal from State permit. Pege Department o Importent: If any Injury or once. as * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Home Enter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Who 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown pinomia 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
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State Registrar use of death (Item 23a) (Type, Print)

32. Registrar's Signature

person who completed c

31. Date filed (Month, Day, Year)

MD. MD

M49269

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

			1- State of Maryland / Department of Health Certificate of Death		Reg. No.	1 600	384/
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) GEORGE ALBERT CANOLES J	2. Date of Month	Day	Year	Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	MORE	Birth Day, Year)	N/A 9. Birthplace (Country) 79 Maryla	(State or Foreign
	D D	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimo		20, 19	10d. In	iside City Limits
	th with the I 23a or 28a-	al Director	10e. Street and Number 1503 Popland St., 10f. Zip Code 212	26-1213	10g. Citiz	zen of What Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It's Modical Examination and the notified at once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Ves 2 No If Yes, specify Cuban, Mexica If Yes, Specify Cuban,		-	4. Race - American Inc Black, White, etc. Specify: Wh	dian,
Maryland 21215-0036	within 72 ho iene. rthan "natur if e Mudical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 10 15. Decedent's Usual Occupation (Give kind of work done during mo	ost of working		employed	,
land 2	ild be filed lental Hyg ked other ilc event.	To Be C	TO	ther's Name (First, Mic Joyce M.		,	
, Mary	and 2 shou alth and M 27 is mai		Joyce M. Canoles (Mother) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num. 1503 Popland St.	hber or Rural Route Nu , Baltimor	mber, City or e, Md.	Town, State, Zip Code 21226–121	3
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 1 □ Cremation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.		Elkri	cation · City or Town, S	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility—Polyn: 237 E. Pataps	iak Funera co Ave., B	l Home alto.,	, P.A. Md. 21225	-1856
	Physician posecuted (Medical Examiner as the burial-transit	ıi Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	as cardiac or respirato	y arrest,	Appr	roximate val Between et and Death
O. Box 68760,	Attending Physician: The law requires that the death certificate be executed riceath. riceath. sector: After this certificate has been signed by the attending physician and better this funeral director, page 2 should be deteched for use as the burial-transit.	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown 1 □ Viscolar Application of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Fregnant at time of death 5 □ Other (specify) □ □ Unknown		_ 2	3d. Date of delivery Month Day	Year
rds, P.O.	n requires that to been signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Morbiol OKS; +4			se contribute to the cau	
Vital Records,	yaician: The law requ is certificate has been director, page 2 should	Completed	Preumonia	a p	vas an utopsy erformed? es 2 12 No	24b. Were autopsy fir prior to complete death? 1 Yes 2	on of cause of
Zit:	/aician: Th s certificate director, pag	To Be	Hospital:	ice of Death Check or Nursing Home 5 - F		Cothes (Secrital	
ion of	nding Physath. rt: After this re funeral di	ation; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2	28d. Descri	be how injury		
Division		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or	n (Street and Town, State)	l Number or Rural Rou	te Number,
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	and place, and due to eath occurred at the tir	the cause(s) ne, date and	and manner as stated. place, and due to the c	ause(s)
)	To the within 2 To the Complet	Σ	29b. Signature and title of certifier 29c. License number			signed (Month, Dey,	
/	held		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	UITT	May	09,2	005
	Sta ~ Registr		RON ELFEN REIN M.D. 3001 S. Ha 31. Date filed (Month, Day, Year) 32. Registrar Signature	nover St	. NM	09, 20	21225

				1 - State of Maryland / Department of Health and M Certificate of Death		giene 005	15848
		Physicia /Medic		1. Decedent's Name (First, Middle, Last) ELIZABETH COLE	2. Date of De	ath Pay 9 m 5	3. Time of Death 3.55A M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Facility Number (If not institution, give street and number) 4c. City, Town, or Location of Death 4c. City, Town, or Location	16		ARUNDEL
		Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mont	8. Date of Bin (Month, Da	19, Year) 1951 M	irthplace (State or Foreign Country) aryland
		Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Baltimore			10d. Inside City Limits 1 Tyes 2 No
		with the	i Director	10e. Street and Number 2 Church St., Apt. D 10f. Zip Code 21225		10g. Citizen of What	Country?
111	36	ours after death with the Marylan ei', or Itama 23a or 28a-f show Examiner must be rictiffied at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Sive Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	ecify Yes or No Rican, etc.)		
Coll	21215-0036	n 72 hc "natur edicel	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) iffe. DO NOT use retired)	ing	16b. Kind of Busines	s/Industry
4		d 2 should be filed withi th and Mental Hygiene. 7 is markad other then traumatic evant, the M	Be Cor		e (First, Middle,	HOUSE , Maiden Sumame)	wite
SUZABETH	Baltimore, Maryland	should tind Ment s markad umatic e	To	Reds Cannon Nor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		nnon er, City or Town, State	, Zip Code)
ARi	e, M	1 and 1ealth 1m 27 thar tr		Charles Cole (Husband) 2 Church St., Apt. D	Balti	more, Md.	
121	timor	Pages nent of ant: if if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Commetery, crematory or other place) Bayview Crematory, Inc. 5/	10/05		
7	Bal	permit. Pag Department Importent: i any injury o once.		21. Sprature of Fineral School Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Fu 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of typing, such cardiac cardiac or heart failure. List only one cause on each line.	neral F	lome, P.A.	21225-1856
		Dhusisian		Shock, of Healt failule. List only one cause of each line.		rrest,	Approximate Interval Between Onset and Death
		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. C2283F51ASCULAR ACCURANT Properties of the constraint of the constrain	1 = -		
		p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Sequentially list conditions, if any, leading to immediate cause. The underlying Cause (Disease or injury that initiated events)	23		
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	Division of Vital Records,	: The law recate has be page 2 sho	Completed		24a. Was autor perfo	an 24b. Were prior t death 1 1 Ye	
	fVita	Physician: r this certificated frall director, in	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		one) dence 6 □Other (Sp	pecify)
	o uoi	nding Pt ith. : After the s funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 48c. Injury at Work? M 1 Yes 2 No	28d. Describe	how injury occurred	
	Divisi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	o Ti Could not be	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
		ne Hospit 124 hour 18 Funare Jetely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
		To th within To th	ğ	29b. Signature and the of certifier 29c. License number D4S 149		29d. Date signed (Mo	2005
	.!	511		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Burn	ie mis	21061
		Sta Regist		31. Date filed (Month, Day Year) 32. Registrar's Signature MAY 1 1 2005			

		•	1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1584	9
	DI		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	_
	Physicia /Medic		George Franklin Cole May 05 2005 06/5	VI .
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			SAINT Agrees HEALTheave Baltimore n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore)	
	Funeral Director		1M 2 F 72 Vrs Months Days Hours Min. (Month, Day, Year)	חנ
			Usual Residence of Decedent	
	trylan show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
	8a-f1	Director	Party I and Date I and	-
	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show official Evertified must be nutillised at		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5565 Oakland Road 21227 United States	
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
9	after or Iter	五	1 ▼ Never Married 2 □ Married 1 □ Wes 2 □ No	
93	ural",	d by	3 Widowed 4 Divorced Year or Dates: 1932–30	
15-	"nate	iete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
21215-0036	filed within 72 ho Hyglene. ther than "natuint, it e Modern	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Coast Guard	
	othe vant,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
<u>lar</u>		ToE	Frank Cole Helen V. Miles	
Maryland	and and Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Cole / Brother 1312 Stevens Avenue, Baltimore, Maryland 21227	
	1 and Healt Bm 2 ther		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town State	
2	90 ≃ 5		1X Burial 2 remation 3 Removal from State Oak Lawn Cemetery 5/9/2005 Baltimore, Maryland	
altimore,	그 돈 뿐 글		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc.	
ä	permi Depar Impo any ir		4107 Wilkens Avenue, Baltimore, Maryland 21229)
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between	
	Pnysician	6 6	Immediate Cause (Final disease or condition a. Muccase I Interement Grant 1	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Muccase! Interest 6 how 6 how 5 ho	
		P.	Sequentially list conditions, I fenoscillate to the sequence or. Due to (or as a consequence or).	<u>r</u>
	uted d ansit	Examiner	Sequentially list conditions, I arry, loading to fining-date cause. Enter Underlying Cause (Disease or injury that initiated events c.	
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9	leath certifica attending pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year	
0	that the dead by the detached	ysic	1 U Yes 2 No 9 Unknown 9 Unknown	
О,	res that igned b	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
rds	w require been sig should b	edt	Hyperterision, Chronic Atria, 1 1 Yes 2 No 3 Probably 4 Martinov	ฑ
ecords,	e law re has be je 2 sho	Completed	24a. Was an autopsy findings availab prior to completion of cause o	le
Œ		Con	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
/ita	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: Other: Othe	
of Vital	9 v =	-T	1 inpatient 2 CHROutpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)	
on	ding Phy th. After thi funeral	tion	27. Manner of Death 1 Pending 1 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurred	
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Ö	tal or A rs after al Direc ed in by	Certification;	4 Homicide building, etc. (Specify) City or Town, State)	
	To the Hospital or Attanowithin 24 hours after death To tha Funeral Director:	edicai	29a. Certifier (Check only (Check only additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To the within 2 To tha complet	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	⊬ ≯ ⊢ 8			
1	4/1	~	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Agar Horp: For I Robert Friends And 980 Cater Arche Ballhouse and 2:229	
L	/ /(
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Regist	tal	MAY 1 1 2005 Record to Control	

ORIGINAL

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			For State	* -		d / Depa	artment of H	lealth and N		-	ible.	LEOFO
			Registrar			Cer	tificate of	Death		Reg. No	00 1	3 8 3 U
	Physici /Medi		1. Decedent's Name (First, Middle, Last Chien Chow						2. Date of De. Month May	Day	Year	:30 P M
	Examir	ner	4a. Facility Name (If not institution, give Greater Baltimore			r	4b. City, Town, o	r Location of Death On		4c. County Ba	of Death	e
	Funeral Director			X 7. A	ge (In yrs. Ia 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jan 12	y. Year) , 1915	9. Birthplace Country) Chi	(State or Foreign □ □
	anyland show	7	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo						Inside City Limits
	th the M or 28a-f e notifie	Director	MD Baltimor 10e. Street and Number	'E	<u> </u>	Towso	10f. Zip Code	,		10g. Citizen of \		1 ☐ Yes 2 ☐ No
	23a	ai	9 Intervale Cour	t			21286			US	SA	
36	within 72 hours after death with the Maryland ene. then "natural" or Itams 23e or 28e-f show the Madical Examiner must be notitied at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces; 1 Tyes 2 If Yes, Give Year or Dates:	Everin U.S No	j.	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 Xo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Ir ck, White, etc. c: Chine	
15-00	n 72 hou "natura edical E	Completed by	15. Decedent's Edu (Specify only highest grad	cation		(Give	lent's Usual Occup	during most of work	ing	16b. Kind of Bu	usiness/Industr	у
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CMÍCN Nand 21215-0036	a la b	To Be C	17. Father's Name (First, Middle, Last)				9211002	18. Mother's Nam- UNK	e (First, Middle, NDWN			
Mary	and and se m		19a. Informant's Name/Relationship (T)	/ре, Print)		19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	r, City or Town,	State, Zip Cod	fe)
₹ %	t and the structure of		Mrs. Dorothy Chow/	wife	20h Blo	9 Inte	ervale Co	ourt, Town	son, MD	21286		
₹ §	S = = 0		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	Removal from State	' '		sition (Name of natory or other place		Date .	20c. Location -		
CHaltimor			'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service License	60)	Рагк		Cemetery		2/2005		/ille, /	
B	permit. Departimport		Michel Po	Stepher	n Cost	er 11	150 York	^{ss of Facility} Rud Road, Too	ok lowso Jaco Mi	on Funer) 21204		e, inc.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that cause	d the death.						App	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	, Derfi	nak	dV	ารเดน	5				set and Death
_	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	10000				-	o
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Box 68	leath certificate b attending physi I for use as the b	/Mec	IF FEMALE:	3c. If yes, outcome	of pregnan	CY.						
	or Attanding Physician: The law requires that the death certifical title death. Jirector: After this certificate has been signed by the attending phin by the funeral director, page 2 should be detached for use as the	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birth 4☐Pregnant a 9☐Unknown	2 Fetal d	death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day	Year
Division of Vital Records, P.O.	law requires that as been signed to 2 should be det	ed by P	Part II. Other significant conditions con	ntributing to death t	out not result	ting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contr es 2 √No		use of death?
Reco	The law requate has been page 2 shoul	Completed							24a. Was a autop perfor	sy / p	Vere autopsy fi prior to complet leath?	indings available tion of cause of
<u>ta</u>	ician: Th certificate ector, pag	BeCc	25. Was case referred to medical					26. Place of Death	1 Yes	210 No 1	☐Yes 2☐	No
Ž	Physici. this cer al direct	ToB	examiner?	fospital: 1 1 Inpati	ent 2 E	R/Outpatient	3□ DOA Othe				er (Specify)	
o noi	ttanding Physician: death, ctor: After this certific y the funeral director.	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ay Year) 2	28b. Time of Injury	28c. Injury Work M 1 🗀 Y			ow injury occurr		
Divis	al or Attan s after deat il Director: id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At hom tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Rou	ite Number,
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best ner: On the basis of and manner st	of examinatio	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the c ed at the time, c	ause(s) and mai late and place, a	nner as stated. and due to the o	cause(s)
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1	071		Aimee F. W	mpleted cause of o	mo	23a) (Type, F	Print) DIN.Ch	oules S	t. Ste 3	3853 Ba	et mo	21204
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 20	32 Aegisti	rar's Signatu	A A	while the					

		_	For Stete Registrer	State of	Marylan		artment o			nd M	ental H	lygier	601	95	15	851
	Physicia /Medic	an	1. Decedent's Name (First, Midd	dle, Last) Kim	N	loses	Ch	ase			2. Date of Month May		Day 20	Year 105		of Death 5 P M
	Examin		4a. Facility Name (If not institution	on, give street and numb	oer)		4b. City, Tow	m, or Lo	cation of	Death			4c. County			
			946 Ellendal					wson		A 11					ce Co.	
	Funeral Director		5. Social Security Number 008–36–5078	6. Sex 7. 1 2 M 2 □ F	. Age (In yrs. 4 9	last birthday) Yrs.	If Under 1 Your Months Da		f Under 2 Hours	Min.	8. Date of (Month, March)	Birth Day, Ye. 17, 1	ar) 956	9. Birthing Court Verman	place (State ntry)	or Foreign
	land ow	1	Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation								Od. Inside	City Limits
	Mary	ţō	MD Bal	Ltimore	1	roewol									1 🗆 Ye	s ACXNo
	h the	Director	10e. Street and Number				10f. Zip Cod	de				10g.	Citizen of	What Cou	ntry?	
	23a (<u>a</u>	946 Ellendale	e Drive			21	286					U.S.A	١.		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event. Ite Modical Examirer must be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	12. Was Deced Armed Forc 1 X Yes 2 If Yes, Give Year or Dat	es?		Was Decedent f Yes, specify (1 ☐ Yes 2 ☐	Cuban, I	anic Orig Mexican, Specify:	jin? (Spe Puerto	ecify Yes or Rican, etc.)	No-		ce - Americk, White, by: White,	etc.	
0	72 ho	ted	15. Decede	ent's Education lest grade completed)		16a. Dece	dent's Usual O	ccupatio	on ina most	of work	na	16b	. Kind of B	lusiness/In	dustry	
21	within 7 ene. than "r	nple	Elementary/Secondary (0-12)		1or 5+)	life.	DO NOT use re	etired)			ng .					
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<u>o</u> E	ages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				natory or other		tiah	5/11/	/0 5	Т	owson,	MD		
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г			23a. Part1. Enter the disease,	or complications that cau	used the deat	th. Do not en									Approxim	ate
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of V	Physician: this certific	10	examiner?	Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3 DOA	Other:	4 🗌 Nui	rsing Ho	me 5	esidence	e 6 □Ot	her (Speci	fy)	
		on:	27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date of (Month	f Injury n, Day Year)	28b. Time o Injury		Injury at Work?			28d. Descri	be how i	njury occu	rred		
sio	eatl or:	catl		stigation			М		s 2 🗆 i	-		(2)			10 -	
Division		Certification;		mined 286. Place	of Injury - At h g, etc. <i>(Speci</i>		reet, factory, of	ffice			28f. Locatio City or	n (Stree Town, S	t and Num tate)	ber or Hur	ai Houte Ni	umber,
	pital ours a oral [29a. Certifier 1 Certifi	ying Physician: To the t	hast of multi-	owledge de-	h occurred at t	he time	data an	d place	and due to	the caus	o(c) and -	20005.22	stated	
	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	edical	(Check only 2 Medic	al Examiner: On the bas and manner	sis of examina	ation and/or in	ivestigation, in	my opin	nion, deat	th occur	ed at the tir	ne, date	and place	, and due t	o the cause	B(S)
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j(XY		30. Name and address of person RIMA COUTS)	on who impleted cause	of death (Ite	m 23a) (Type	_	BA	HUTIN	401	Ē,	M.	D 21,	224	ł	
	Sta Regist		31. Date filed (Month, Day, Year MAY 1 1 2		egistrar's Sign	ature	رع									

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Amend Item#20b, per FH G843 5/16/05 CC

Amend Item#20b State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:43 PM CHYBA MAY 2005 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARKIAND MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 1, 191 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Months Davs Hours 87 212-12-0922 Yrs Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County worke item 27 is marked other than "natural", or itams 23a or 28e-f show other treumatic event, the Medical Examinant minative modified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8718 Summit Avenue death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 end 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent of Health and Mental Hygiene. ent; If item 27 te marked other than "natural", or itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Social Security 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Kaisler Joseph Santora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Michele Chyba (daughter) 24207 Norchester Way, Spring, TX 77389 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 5/13/05 permit. Pages 1
Department of H
Importent: If Ite
any injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Most Holy Redeemer 12/13/2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS ~2 wks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner siclen and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical phys s the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9□ Unknown 9 Ni Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier P 18600 s of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 22 S. Greene ffrey LIU, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of He rtificate of D		lental Hygie	4005	15853
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Elinor Lafferty (Cook				May 5, 20	005	12:50 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L			4c. County of Dear	th
			Charlestown Reti	ement Cent	ter		Catonsvi	.11e	Ba1	timore
	Funeral Director		5. Social Security Number 6. S 219-10-9730	ex 7. Age □M 2XIF	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo Jan. 13,	9. Bin 2015 M	thplace (State or Foreign buntry) aryland
	g ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	nation				10d. Inside City Limits
	shov	<u>-</u>			Too. Only, Town of Ec					1 Yes 2 No
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	e or	Ē	709 Maiden Choice	a Tana Ant	FH101	101. 24 0000	21228	1.59	United S	
	eath rrus	era	11. Marital Status	12. Was Decedent B		Was Decedent of His		ecify Yes or No-	14. Race - Ame	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or Items 23e or 28e-f show amy injury or other treumatic event. I've Medical Examiner must be notified at ance.	by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ∑ N If Yes, Give Year or Dates:		If Yes, specify Cuban, 1 ☐ Yes 2 🖾 No	Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	white
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yland	Ment Ment arkec	2	Eugene Francis L	afferty, S	r.		E]	lsie Emma	Rebecca	Lippy
Mar	2 sho and is m	N H	19a. Informant's Name/Relationship (ng Address (Street ar			-	
,,	and ealth m 27	12	Carolyn Cook Spr	ing Daugh		Arlewood F				
ם כ	ges 1 t of H if ite		20a, Method of Disposition 1 △ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place,		Date 20	c. Location - City or	Town, State
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baitimore,	Depar Impor any in	(21 Signatori o Fun	300	VIII INI IX	2. Name and Address 328 Sulphu				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dying,	, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as:	a consequence of):					
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287		edical		_ d						
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ı.	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not resulting in the i	underlying cause give	n in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
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<u></u>	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				26 Place of Deat	h (Check only one)	No 1 Yes	s 2 No
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ļ	To the within To the comp	Me	29b. Signature and title of contifier	1 m)	29c. License	number 747	290 V	1. Date signed (Mon	th, Day, Year)
	7		30. Name and address of person who		leath (Item 23a) (Type	Print) Choice	Land	Cators	ile ma	p.t
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	Regist		MAY 1 1 201	15 from	ar's Signature					

			1 - For State Registrar	State of Ma	aryland		artment of rtificate o			lental Hy	/giene	005	15854
44	Physici /Medic		1. Decedent's Name (First, Middle, La HAROLD E	DWARD		_	Cox			2. Date of D Month MAY	eath Day	2005	3. Time of Death 12:58 P M
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	with the Marylan or 28a-f show	Director	10a. State 10b. County MD n/a 10e. Street and Number		Balt	imore	10f. Zip Cod	e 227			_	en of What Cou	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: if Item 27 ie marked other than "natural; or Items 23e or 28a-f show any injury or other treumatic svent, the Mydical Examinar must be notified at once.	d by Funeral	3211 Lily Ave. 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 凶 If Yes, Give Year or Dates:			Was Decedent of Yes, specify 0	of Hispanic C Juban, Mexic			0- 14	d State 4. Race - Ameri Black, White Specify: Wh:	ican Indian, , etc.
Maryland 21215-0036	ed within 72 h ygiene. ier than "natu t, the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10	ade completed) College (1-4or 5	i+)	(Give life.	dent's Usual Oc kind of work do DO NOT use re bly Mec	ne during mo tired)	ost of work	ing		of Business/lo	ndustry
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Balt	permit. Depart Import any inj		21. Signature of Funeral Prvice Lice	Molle		2	719 Ham	monds	Ferr	y Rd. I	ansdo		ofLansdowne yland 21227
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			For State Registrer	State of IVI	aryland / Dep.	artment of He rtificate of D			ne . No. 005	15855
I	Physici		1. Decedent's Name (First, Middle, La Jeffrey W.	•				2. Date of Death Month May 4, 20	Day Year	3. Time of Death 2:10 P M
	/Medio Examir		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or I	ocation of Death	ray 4, 20	4c. County of Death	
	Francis		401 Flying Point Roam 5. Social Security Number 6.5		e (In yrs. last birthday)	Edgewoo		8 Date of Birth	Harford	place (State or Foreign
ı	Funeral Director		148-36-3930		59 Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day, X December 2	2, 1945 New	Tork
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation	-			10d. Inside City Limits
	Ba-f sh	ctor	Maryland Harford		Edgewo	. ,				1 ☐ Yes 2 No
	ath with the 23e or 2	ral Dire	401 Flying Point Road			10f. Zip Code 21040		10g	. Citizen of What Cou USA	ntry?
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or iteme 23e or 28a-f show event. The Medical Exartifar must be notified at	d by Funeral Director	11. Marital Status 1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:	No.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	panic Origin? (Spe , Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify. White	etc.
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event. The M	Be	17. Father's Name (First, Middle, Last Harold Carlsen	")			18. Mother's Name Dolores		iden Sumame)	
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	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		Patricia Gallagher/C	Cousin		Elm Street				
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ 1 □ Donation 5 □ Other (Speci	4.)	Hillton Ser	psition (Name of matory or other place, vice Corp.	5/10	/05 To	c. Location - City or T DWSON Marylar	
Ball	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Lice Chustina &	nsee Christina Hettor	L. Hilton	2. Name and Advess Chard . UC 805 Hartord R	of Facility K. Inc Wood Dalti	iore Maryla	and 21214	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	d the death. Do not en	ter the mode of dying,	such as cardiac of	r respiratory arrest	cular d	Approximate Interval Between Onset and Death
./	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as	a consequence of).					
٥, ۸	cate be executed physician and the burial-transit	i Examiner	resulting in death) Last	cDue to (or as	a consequence of):					
68760,	tificate by physicas the b	edicai		d						
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	rery Day Year
Records, P.	w requires that been signed b should be dete	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the u	inderlying cause given	in Part I.	23e. Did tobad	cco use contribute to t	the cause of death?
al Reco		Completed						24a. Was an autopsy performe 1 Yes 25	24b. Were autoprior to codeath? No 1 \(\text{Yes} \)	opsy findings available impletion of cause of 22No
Vital	Physician: this certificatal director, p	o Be	25. Was case referred to medical examiner? 11 Yes 2 □ No	Hospital:	ent 2 ER/Outpatie	Other	26. Place of Death	(Check only one)	e 6 □Other (Speci	fu)
ion of	ding Pt J. After th funeral	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da		f 28c. Injury a Work?	at 2	8d. Describe how		77
Division	2 9 2 6	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj	ury · At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hoepitel or within 24 hours afte To the Funerel Dir completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Pi 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the time evestigation, in my opin	, date and place, a nion, death occurre	nd due to the caus d at the time, date	se(s) and manner as s and place, and due t	itated. o the cause(s)
	To t withi To tl	X	29b. Signature and title of certifier	100	1 1	29c. License	number	29d.	. Date signed (Month,	Day, Year)
			30. Name and address of person who	completed cause of	leath (Item 23a) (Type	Print)	1206	M	ay 5, 200	5
	1		BERNARD J. V	WKNA IM	D. DRE	7018 HOL	A BIRD	AVE B	ALTO MO	12122
	Sta Registi		31. Date filed (Month, Day, Year) /	32. Registr	als Signature	Spected				

	1 - For State of Maryland / Department of Certificate of Certifica			0000	The pag person on
	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. I 2. Date of Death		3. Time of Death
Physician /Medical	Ruth Ann Connolly		Month 8	Day Year 2005	8:42 A M
Examiner		, or Location of Death		4c. County of Death	
	Suburban Hospital Bethe 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yea			Montgomery	
Funeral Director	5. Social Security Number 132-14-7125 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Months Day 19. Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth <i>(Month, Day, Yei</i> February 16	9. Birthp Cour New	lace (State or Foreign htry)
	Usual Residence of Decedent		Tobleanly 10	, 1920 New	TOTA
show	10a, State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with the Maryla 23a or 28a-1 shov ust be motified at	Hampshire Hillsborough Hollis 10e. Street and Number 10f. Zip Code		100	Citizen of What Cour	
3a or	28 Ridge Road 030			ited State	•
death	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto F		14. Race - Americ Black, White,	an Indian,
036 ours after de et, or items Exacultur	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No		iloan, olo.)		ite
nd 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural; or items 23s or 28s-1 show event, the Modical Examitter, was be notified at the Completed by Finneral Director.	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	upation	16b	. Kind of Business/Inc	
Ind 21215-0 be filed within 72 ho tal Hygiene. of other than "natur event, the Modical	(Specify only highest grade completed) (Give kind of work don life. DO NOT use retired in the content of the co	e during most of workin red)	g		200.19
nd 21. Be filed will Hygien other th.	12 Homemaker			Own Ho	me
	17. Father's Name (First, Middle, Last) Alexander Scott	18. Mother's Name Edith P		len Sumame)	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours aft Health and Mental Hygiene. Item 27 is marked other than "natural", or other treumatic event, the Modical Exeruit TO Re Commisted the	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street			y or Town, State, Zip	Code)
Mand 2 and 2 seath a m 27 is	Karen M. Connolly / Daughter 28 Ridge Road				
Baltimore, M. permit. Pages 1 and 2 Department of Health a Importent: If them 27 is any injury or other tree once.	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	lace) May 1	1.	Location - City or To	wn, State
Itim it. Pag rtment rtent; njury	`4 □Donation 5 □Other (Specify) Montgomery Crematoriu			thesda, Ma	
Balti permit. Departm importe any inju	MO1305 Robert A. P. 7557 Wiscons	ress of Facility Imphrey Funera Sin Avenue, Be	l Home/Beth thesda, Mar	nesda-Chevy (yland 20814-	Chase, Inc. -3501
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line.	ying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) Ventricular Tachycardia	a		D	ays
	Due to (or as a consequence of): Nonischemic Cardiomyopa	athy		Y.	BETE
Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
0, an and an and unial-transit	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8.42, 8760, cate be executed physician and ithe burial-transit dical Examir	d				
	0.				
Records, P.O. Box 6. The law requires that the death certific the has been signed by the attending page 2 should be detached for use as completed by Physician/Mer.	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant	cy		23d. Date of delive	•
O. E. O. E.	1 ☐ Yes 2 🖾 No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown			Month	Day Year
15, P.O. res that the digned by the be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
Cords, requires been sign should be			1 🗆 Yes	2 □ No 3 □ Prob	ably 4 Dunknown
of Vital Record Physicien: The law requir this certificate has been s all director, page 2 should			24a. Was an autopsy	24b. Were auto	osy findings available inpletion of cause of
			performed? 1 ☐ Yes 2 🔯 I	? death?	
Vital Vital Sicien: Certifica	25. Was case referred to medical examiner? Hospital:	26. Place of Death	And the second second second second		
OO nof No ser this contribution To	1 ☐ Yes 2 🖫 No	ther: 4 \(\sum \) Nursing Hom ury at 28	Bd. Describe how in		")
Vision of Vita vision of Vita Attending Physicien: death. setor: After this certific by the funeral director, fification: To Be	1 X Natural 5 ☐ Pending (Month, Day Year) Injury W 2 ☐ Accident investigation M 1[onk? □Yes 2□No			
Z Segigi	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	9 28	8f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
Hospi Houner Hou	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the pass of examination and/or investigation, in my and manner stated.	time, date and place, ar opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
To the P within 2 To the Complet	29b. Signature and title of certifier 29c. Licer	nse number	29d. [Date signed (Month, I	Day, Year)
	Nanay Davenport 410	57	Ma	ay 8, 2005	
That	30. Name and address of person to completed cause of the (Item 23a) (Type, Print) Nancy Davenport, M.D. 3301 New Mexico Avenue	, Washingto	on, D.C.	20016	
State Registrar	31. Date filed (Month, Day, Year) 32. Registar's Signature MAY 1 1 2005				

GLORIA	CONNE	LL	For State Registrar	State of	Marylar		artment of rtificate of		d Mental H	ygiene Reg. No. 00	5 5857
			1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath	3. Time of Death
	Physici /Medio		G	loria I. (Connell				Month	-	1742 P M
	Examir		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Town,	or Location of [Death MAY	7, 2005 4c. County of	Death
			SHADY GROVE ADV	ENTIST HO	SPITAL		ROCKVI	LLE		MONTGO	MERY
	Funeral				7. Age (In yrs.		If Under 1 Yea Months Days		Hrs. 8. Date of B	oay Year) 12, 1944	Birthplace (State or Foreign Country)
	Director		434-72-4177	1□M 2∏F	60	Yrs.		1	November	r'12 , '1944	Texas
3	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cir	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ō	Maryland Montgo	omerv		_	rsburg				1 ☑ Yes 2 ☐ No
	286	<u>5</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
	oth with the Marylar 23e or 28e-f show unt be notified at	<u>=</u>	108 Apple Bloss	som Way			2087	8		United S	
-	filed within 72 hours after deeth with the Maryland Hygiene. Hygiene Hygiene than *natural", or Iteme 23e or 28e-1 show ent, the Mari cal Examitter roual be notified.	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or Note of Rican, etc.)	o- 14. Race -	American Indian,
ယ္ -	or Ite	3	1 X Never Mamed 2 ☐ Marrie	Armed For	2 🔀 No		lf Yes, specify Cui 1 ☐ Yes 2 🛣 No		Puerto Rican, etc.)		White, etc.
33	72 hours natural', lical Exu	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1 Tes 2 Mino	Specify:		Specify:	White
2	natt.	Completed	15. Decedent' (Specify only highest			16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation a during most of	working	16b. Kind of Busin	ness/Industry
121	within the the the the the the the the the the	E E	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOTuse retir istrativ			Fodorol	Government
N :	Hygie ther t	ပိ	17. Father's Name (First, Middle, L	ast)		AdiiTi	ISCIACIV	_		e, Maiden Sumame)	Government
and	ould be f Mental F varked of natic ever	Be	Gordon H. Conne						McPherson		
<u> </u>	should nd Men marke umaric	ဥ	19a. Informant's Name/Relationsh			19b. Maili	ng Address /Stree			ber, City or Town, Sta	ate Zin Code)
	2 4 7 5		Vicki M. Bolling	g / Sister	-						laryland 20878
ē,	a 9 E 9	1 3	20a. Method of Disposition		20b. F		sition (Name of matory or other pla		Date	20c. Location - Cit	
e i	Page nento nr:⊮ ryor		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				Crematoriu	_ ma	y 10, 2005	Bethesda	, Maryland
i i	permit. Pages 1 Department of H Importent: If Iter any Injury or oth once.		21. Signature of Funeral Service			2	2. Name and Addr			Rockville,	
m i	g 2 E 8 8		Ungelette De	maint	M0130	5 30	bert A. Pu O West Mon	mphrey fu ntgomerv A	meral Home, Avenue, Roc	Kockville, kville, Mar	Inc. yland 20850–2805
			23a. Part1. Exer the disease, or on shock, or heart failure. List of	complications that ca	used the deat						Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	Hupar	tensive	atto	nsclovet	ic Can	dio large	on diseas	Oncet and Death
	/Medical Examiner		resulting in death)		r as a conseq		VODUCE		0 10 18301	31360	~
	-xammer	_	Sequentially list conditions,	b							
-	pe gr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseq	juence of):					
	xecuted and il-transit	xan	that initiated events resulting in death) Last	c	r as a conseq	luence of):					
8760,	ate be ex hysicien a the burial	dicai E	,			,					
687	ine law requires mat me deam certilicate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transt	edic		d							
Xo	eath certific ettending pl for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc						23d. Date o	of delivery
n i	death e ette	icia	in the past 12 months?	4□Pregna	nth 2 ☐ Feta unt at time of d]Ectopic pregnand] Other <i>(specify)</i> _	-y		Month	
0.	that the de ned by the e detached i	hys	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno	WT						
S,	ep eq ep eq	by P	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
ord	been si should I	ted							_ 1□	Yes 2 □ No 3{	□ Probably 4 Dunknown
မင် မင်	as be	pie							24a. Wa		re autopsy findings available ir to completion of cause of
<u>~</u>	ine lav	Completed								ormed? dea	th? Yes 2 No
/ita	Attending Priystoten: In r death. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?						Death (Check only	one)	
£ [rnysi this o	ို	1 XYes 2 No			ER/Outpatier	I JU DUA			idence 6 Other	'Specify)
מט	After funer	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurred	
Sic	death. ctor: A y the fu	Icat	2 Accident investiga 3 Suicide 6 Could no	ot be	- 6 l-1]Yes 2□No	204 1		
<u> </u>	or A after Direct in by	Certification:	4 ☐ Homicide determin	buildin	g, etc. (Specif	y)	eet, factory, office		City or To	(Street and Number o wn, State)	or Rural Route Number,
_	Hospital 24 hours a Funerel tely filled		29a. Certifier 1☐ Certifying	Physician: To the I	est of my kno	wledge deat	1 occurred at the t	ime date and n	lace, and due to the	cause(s) and manne	ar as stated
3	volue hospital or Attentwithin 24 hours after deal To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical E	xaminer: On the ba	sis of examina	tion and/or in	vestigation, in my	opinion, death o	occurred at the time	date and place, and	due to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier					se number		29d. Date signed (A	
	1		I min t	vi mij			0	CME		MAY 8,	2005
11	10		30. Name and address of person w	to completed cause	of death (Iten	n 23a) (Type,	Print)	<u> </u>			1 1 04004
10			LING LI,	miD			111 Pen	n Stree	t Baltim	ore, Mary	land 21201
	» Sta	- 10	31. Date filed (Month, Day, Year)	32. Re	gistar's Signa	ature 🕢	Spertis				
	Registr	ar	MAY	7 1 2005	Clasies-	, 50.					

		ļ	For State Ragistrar	State of Ma	aryland / [artment of rtificate			ental Hy	/giene Reg. No.		
	Physicia		1. Decedent's Name (First, Middle		Co114	20				2. Date of De Month	-	Year	3. Time of Death
	/Medic Examin		A PT TO AN AN AND AN AN AN AN AN AN AN AN AN AN AN AN AN						n of Death	rıa		ty of Death	13:20 PM
	Funeral		Manor 5. Social Security Number	Care Bethesd	e (In yrs. last bir		If Under 1 Ye	ar If Und	esda er 24 Hrs.	8. Date of Bi	rth ay, Year)	Mont	gomery place (State or Foreign intry)
	Director		578-32-6507	10 W 210	90	Yrs.				July 2	5, 1914		Kansas
	lend		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	ocation						10d. Inside City Limits
;	feh	ō	Marry land Ma	- t				D a dela a					1 ☐ Yes 2 🛣 No
	r 28a	Directo	Maryland Mo 10e. Street and Number	ntgomery			10f. Zip Coo	Bethe	esaa		10g. Citizen of	f What Cou	untry?
	3a o		5106	Battery Lane	2			208	1.4		II.	nitod	Ctatas
	deetl	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent If Yes, specify (ify Yes or N		ace - Ameri	
215-0036	a within 72 hours after deeth with the Marylend Jiene. I than "insturel", or iteme 23a or 28a-f ehow If a Medical Exercit seriment to inclifical at	by	1 ☐ Never Married 2 ☐ Marria 3 🛣 Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 📉 N	10	1	niYes, specnty (1 □ Yes 2 🛣			tican, etc.)	Spec	ack, White, :ify:	White
5	72 ho	ted		it's Education st grade completed)	16a	. Deced	dent's Usual Oc	cupation	act of workin		16b. Kind of	Business/îr	
7	c * 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	kind of work do DO NOT use re	tired)	OSI OI WORIN	g			
2	e filed within ! Hygiene. other than "	Co		2		Ad	ministr						Church
Maryland 21	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle,	Last)				18. Mo	ther's Name	(First, Middle	a, Maiden Suma	іте)	
<u>Ş</u>	should ind Men s marke umatic	T _o		Walter Mund							ry Schi		
<u>a</u>	12 sh hand 7 is n traun		19a. Informant's Name/Relations		196						per, City or Town		
	es 1 and 2 should be f of Health and Mental F f item 27 is marked of r other traumatic ever		Gregory M. Co	Ilins/ Son	20b, Place o		O105 G1			Fairt	ax, Vir		
Baltimore,	Peges nent of int: if it iry or o		1 K Burial 2 ☐ Cremation		⊢ Gate		natory or other		М	av			
	permit. Pege Department important: ii eny injury o		* 4 □ Donation 5 □ Other (S 21. Signature of Feheral Service		of H	eav	en Ceme	tery	12,	2005	Silver	Spri	ng Maryland
ä	Dep imp eny			0x /1	, M00335	Be	thesda-	Chevy	Chase	Inc.	7557 W	iscon	neral Home/ nsin Avenue
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition	_									Onset and Death
	/Medical		disease or condition resulting in death) Severe Anemia Due to (or as a consequence of):										
	Examiner		Sequentially list conditions.		Failure								
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence	Jence of):							
	and and I-tran	хап	that initiated events resulting in death) Last	c. Lung C.	ancer a consequence	of):							
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O. Box	at the deeth certifi by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of Month		ate of deliv Month	rery Day Year
ري ح	es that igned b	by PI	Part II. Other significant conditi	nderlying cause	erlying cause given in Part I. 23e. Did tob				bacco use contribute to the cause of death?				
ğ	law requires that the es been signed by th 2 should be detache									1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MagUnknow		
Vital Records,	0 4 0	ompieted										prior to co death?	opsy findings available ompletion of cause of
<u>E</u>	sicien: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?					26. Pla	ce of Death	(Check only		103	20110
0	dis	To	1 ☐ Yes 2 X No	Hospital: 1 Inpatie	nt 2 ER/Ou	utpatien	nt 3 DOA	Other: 4X	Nursing Hom	e 5 ☐ Res	idence 6 🗆 Ot	ther (Speci	(ty)
ב	ding Pt After th funeral	on:	27. Manner of Death 1 X Natural 5 □ Pendir	28a. Date of Injur (Month, Day		Time of Injury	1	njury at Work?		8d. Describe	how injury occu	irred	
Sio	tend leath tor: /	cati	2 Accident investi	not be				1 □ Yes 2					
Division	APOS	Certification:	4 Homicide determ		ury - At home, fa c. (Specify)	arm, str	eet, factory, off	ice	2		(Street and Nurr wn, State)	iber or Run	al Route Number,
	he Hospitei or in 24 hours efte he Funerei Dirk pletely filled in t	edical	29a. Certifier 1X Certifyii (Check only 2 Medical one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examination an	e, death	h occurred at the vestigation, in n	e time, date ny opinion, d	and place, a eath occurre	nd due to the d at the time,	cause(s) and m , date and place	nanner as s , and due t	stated. to the cause(s)
	To the H within 24 To the F	3	29b. Signature and title of certifie	1 Al re	mi	ク	29c. Lic	ense numbe	r		29d. Date sign	ed (Month,	Day, Year)
٠,	01		put	700				D-2	0274		Ma	ay 8,	2005
	U'		30. Name and address of person								A Ref Service		
	Sta	te	Kirta 31. Date filed (Month, Day, Year,	Vohra M.D.	/710 B ar's Signature	rad	le By	levaro	Beth	esda,	Marylan	d 208	17
	Registr		SEAV	Vohra M.D. 32. Registra 1 1 2005	Muse !	U·	19						

			1 - For State Registrar	State of M		Depa	artment of H	ealth and	Mental Hyg	_	05	15859
	Physici		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Mattie	Ε.		Da	vidson		May	10.	2005	12:20PM M
	Examir	ıer	4a. Facility Name (If not institution)		4b. City, Town, or	Location of Dea	th	4c. Cour	ity of Death	
	•		Chesapeake Hosp 5. Social Security Number		no //n uro lo et h	inth days	Linthi If Under 1 Year	CUM If Under 24 Hrs	Dot- d Divi		ne Ar	rundel
	Funeral Director		218-26-9727	1 □ M 2 DF	ge (In yrs. last b	Yrs.	Months Days	Hours Min	. (Month, Da)	v, Year)		place (State or Foreign intry)
			Usual Residence of Decedent		94				Feb. 04	+,1911	Ken	ıtucky
	rylan thow		10a. State 10b. County		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	Se-f s	Director		Arundel	Mille	ersv	ille					1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number	1			10f. Zip Code			10g. Citizen o		-
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or itams 23a or 28e-f show avent, the Medical Examinar must be motified at	Funeral	307 Dogwood Roa		Fuer in II C	10.1	21108		2		U.S.A	
40	itam iner	-un	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces ed 1 Yes 2 7	? _	13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (n, Me xican, Puei	to Rican, etc.)	14. H	ace - Ameri lack, White	
936	urs a	þ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□ Yes 2☑ No	Specify:		Spec	eify: Whi	to
Maryland 21215-0036	72 ho	Completed	15. Decedent (Specify only highes	's Education	168	a. Dece	dent's Usual Occupa kind of work done d	ition	addin a	16b. Kind of		
7	within lene. than "	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired,)	ikiig			
2	filed within Hygiene. ther than "		8	N/A			Housewife				n Hom	ıe
auc	buld be fi Mental H arked ot atic aver	Be	17. Father's Name (First, Middle, I	_asi)					me (First, Middle,	Maiden Sum	ame)	
Ž	d 2 should be th and Menta 7 is marked traumatic av	To	011ie 19a. Informant's Name/Relationsh	in (Type Print)	Sarge	ent b Mailie	ng Address (Street a	Virgi	David Alumba		ewis	- C-4-1
Z	12 sh ar		Mary C. George		13							· C-0000015
ē,	s 1 and of Healt itam 2 other		20a. Method of Disposition		20b. Place	of Dispo	Dogwood sition (Name of matory or other place	Koad HI.	Date	20c. Location		
Ë	0 0		1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		'		dge Mem.	1	13/05	Eller:	d M	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service I	icensee	rieau(22 M	Name and Addres	s of Facility	13/03	FIKLI	dge M	aryland
m	Per E G	t ia	John F.	Collins		3	cCully-Po 204 Mount	lyniak l ain Road	funeral H 1 Pasaden	lome, P na Mar	A. Vland	21122
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between									
	nysician	i n	Immediate Cause (Final disease or condition advanced demant							4a		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):								1000	
	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury	Due to (or a:								
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):						
8760,	law requires that the death cartificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ical		d.								
Ö	tificat ig phy as th	ledi										
Вох	eath certific attending p for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1						1		te of delivery	
	e dea he att	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknow		t time of death		Other (specify)			, N	Month	Day Year
P.0	at the de d by the a	Phy			52							
js,	ires that signed to be det	by	Part II. Other significant condition	ns contributing to death	out not resulting	in the u	nderlying cause give	1 00		La 3		the cause of death?
0.00	w requir been si should I	etec	C E D	- Cy y	7100	1	Chron		(In 10Y	es 2 No	No 3 Probably 4 Unknown	
Records,	The law ate has t	Completed	Sylverione	, taxiun	2.10	1270	rive,		24a, Was a autop	SV	b. Were auto prior to co death?	opsy findings available empletion of cause of
all			noragena	rian						rmed? 2 No	1 Yes	2 No
Vital		o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \)	Hospital:	a 🗆 = 5 to		othe		ath Check onl or			11-2-0
of	g Physical dispersal di		27. Manner of Drath	1 ☐ Inpat 28a. Date of Inj	ury 28b.	. Time of	IL 30 DOX	4 🗀 (Antelling)	Home 5 Resid		ther <i>(Speci</i> urred	Willes Pice
ion	nding I ith. :: After e funer	ation	1 Natural 5 Pending		ay Year)	Injury		? ′es 2 ∐ No		,,		House
Division	I or Attandii after death. Director: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	286. Place of it	jury - At home, t	farm, str	eet, factory, office				nber or Run	al Route Number,
Ö	ital or A rs after al Directed in by	Certification:		balloling, e	io. (opocity)				City or Tow	m, Siale)		
	he Hospital o in 24 hours aft ha Funaral Di pletely filled in	edicai	(Check only #2 Medical I	g Physician. To the bes Examiner: On the basis	of my knowledg	ge, death	occurred at the tim	e, date and place	e, and due to the d	cause(s) and r	nanner as s	stated.
	To the Hos within 24 h To tha Fur completely	Medi	Oney	and manner s	tated.							
1	5 M 5 0	-	29b. Signature and title of certifier	and,	15	ب	29c. License	PC/10	30	29d. Date sign	nea (Month,	Day, Year)
j	11/	. 19						V-11	72	2	70 "	James
6) (alle crack	who completed cause of) / Sa	Le ype,	aho H	661.10	204/	11 200	2 Sich	llomo
	Sta	ite	81. Date filed (Month, Day, Year)	32. Regist	rar's Signature	-	- (7)	,,	7/		001	
**	Regist		M	AY 1 1 2005	Le .		& Such					

			1- For State of Maryland / Dep	eartment of Health and Nertificate of Death		liene	15860
	Dhorist		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th	3. Time of Death
	Physicia /Medic		Marjorie Ellen Dunnock		May	5, 2005	12:50 P _M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Renaissance Gardens 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Catonsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	
	Funeral Director		213-20-5061 ^{1□M 2} ² F 94 Yrs.	Months Days Hours Min.	Oct 30	Year) Country	ce (State or Foreign y) 7land
	ס		Usual Residence of Decedent		500 00	•	
	show	7	10a. State 10b. County 10c. City, Town or I Maryland Baltimore Catons			10d	f. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-1	Funeral Director	Maryland Baltimore Catons 10e. Street and Number				
	with with Ba or	ğ	715 Maiden Choice Lane HV 205	10f. Zip Code 21228		log. Citizen of What Country USA	11
	deeth	Jera	11 Marital Status 12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American	ı Indian,
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at		Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc	
5-0	72 hc 'natur	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business/Indus	stry
121	within ene. then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		1	Bank	
d 2	Hygie ther ther	e Co	10 Tell 17. Father's Name (First, Middle, Last)			Maiden Sumame)	
an	id be ental ked o	m	Samuel McNeil			Binnix	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Run			ode) 21042
	and 2 saith a n 27 is		H. Joyce McNeil - niece 992	9 Carrigan Driv	e, Elli	icott City,	MD
Baltimore,	Jes 1 of He If iten		20a. Method of Disposition 20b. Place of Disposers 20b	ematory or other place)		20c. Location - City or Town	
ţ	Pages tment of h tant: If its		'4 □Donation 5 □ Other (Specify) WOOGIA	wn Cemetery 5/9			
Bal	permit. Page Department I Important: If any injury or once.		1 1000 16 51 00 16	22. Name and Address of Facility Hu			
			23a. Part1. Enter the disease, of complications that caused the death. Do not en	4107 Wilkens Av	enue, E	<u>Baltimore</u> ,	MD 21229
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	mylysema	,,	In O	nterval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequence of):	- who when a			
п	Examiner		Sequentially list conditions, b.				
_	pe IIs	iner	if any, leading to immediate cause. Enter Underlying Course, Olisease of Irijury				
	cate be executed obysician and the burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	sician buria	dicai E	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				
687	ificate g phys as the	edic	d		2		
Вох	death certific e attending p od for use as f	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of delivery		
	0 0 0	sicis	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Da	ay Year
P.0	requires that the di een signed by the hould be detached		9 ☐ Unknown Part II. Other siggificant conditions contributing to death but not resulting in the	underhing grupp grupp in Part I	220 Did tob	bacco use contribute to the	source of doubt?
ds,	es un es	d by		varuen Peroa	236. Did (00	1	
Vital Record	> 4	ompieted			24a. Was a	7	y findings available
Re	The law ate has b page 2 sl	dmo			autops perform	y prior to comp	eletion of cause of
tal	ician: Th certificate ector, pag	C	25. Was case referred to medical	26. Place of Deat			□ No
<u>></u>	dis di	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	011		ence 6 ☐Other (Specify)	
n of	ding Ph th. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury			ow injury occurred	
slo	Attending r death. ector: After by the fune	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	after d Direct d in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	treet and Number or Rural R n, State)	loute Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	ledicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the control of the best of my knowledge, deal of the control of the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the carred at the time, da	ause(s) and manner as state ate and place, and due to th	e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier James	29c. License number	00/100 25	9d. Date signed (Month, Da	yr, Year)
1	N		30. Name, and address of person who completed cause of death (Nem 23a), (Type	Print)	Can	5/9/C	orland
7			V Crans Nap 711 Md	all house	cane	1	2/228
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DH	Registi IMH 17 Rev 1/2	- 5	MAY 1 1 2005 Marie &	to No		320000	
Di		.001	MAY 1 1 2005 Steve & ORIGIN	AL			

Helen E. Dorman 55# 214-32-0283

		1_ For Stete			d / Dep	artment	of Health a	re All Copie and Mental H		_	-
Physic		Registrar 1. Decedent's Name (First, Middle, Las HELE	-	-			of Death	2. Date of D Month		ay Year	3. Time of Death
/Medi- Examir Funeral Director		4a. Facility Name (If not institution, give PUI INSUID REGION 5. Social Security Number 6. Security Number 114-32-0283	street and number)		DOR CUNFA last birthday, Yrs.	4b. City, To	wn, or Location of SOUS SOUR SOUR SOUR SOUR SOUR SOUR SOUR	of Death	irth Day, Year	c. County of Deat	h OO hplace (State or Foreig untry)
ne Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Somer	set	10c. City	y, Town or Lo	ocation	Prince	ss Anne			10d. Inside City Limits 1 □ Yes 2 ☑ No
ath with the 23s or 2		10e. Street and Number 10432 Eagle Drive				10f. Zip C	21853			itizen of What Co USA	untry?
is 1 and 2 should be filed within 72 hours after death with the Maryland attents and Mental Hygiene. Items 12 is marked other then "naturel", or items 23a or 28e-f show other treumetic event, Ite Marylast Examinations.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Amed Forces? 1 ☐ Yes 2 1 ↑ If Yes, Give Year or Dates:				t of Hispanic Orig Cuban, Mexican No Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	10-	14. Race - Ame Black, White Specify: Wh	e, etc.
ad within 72 h giene. er then "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	(Give	DO NOT use	done during most	of working		Kind of Business/	Industry
d 2 should be filed in and Mental Hygis 7 is marked other treumetic event, III	To Be C	17. Father's Name (First, Middle, Last) Allie Lee					18. Mother Len E	r's Name <i>(First, Middl</i> Clizabeth I	e, Maide Kella	n Sumame) aM	
1 and 2 shi Health and em 27 is m		19a. Informant's Name/Relationship (7 Beth Kitching (Gra 20a. Method of Disposition			10434		Drive -	r or Rural Route Num. Princess Date	Anne	e, Maryla	and 21853
permit. Pages 1 ar Depertment of Hea Importent: If item any injury or othe		1 Magurial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens)	C	emetery, cre sfield	matory`or othe Cemet	r place) ery 5	5/7/05 S Funeral	Cris	_ocation - City or in Sfield, I	
Physician /Medical Examiner	Examiner	Mary Beth Bra 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	lications that caused	the death	Do not and	306 W.	Main St	reet - Cri	sfie	eld, Mar	Approximate Interval Between Onset and Death year / year / monta
death certificate be executed e attending physician and nd for use as the burial-transit		resulting in death) Last	Due to (or as								
the death cer y the attendir iched for use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetel	death 3	Ectopic pregi Other (speci				23d. Date of delin Month	very Day Year
The law requires that the de tte has been signed by the a bage 2 should be detached t	by	Part II. Other significant conditions co	ntributing to death be	it not resu	iting in the u	nderlying caus	e given in Part I.		_		the cause of death?
	e Completed	25. Was case referred to medical						1 ☐ Yes	opsy omed? 2 1 No	prior to o death?	opsy findings available ompletion of cause of 2 1 No
Physicien: r this certific ral director,	To B	examiner?	Hospital: 1 (Impatie	nt 2 🗆 l	ER/Outpatien	it 3□DOA	Other	of Death <i>(Check only</i> sing Home 5 ☐ Res		6 □Other (Spec	ify)
Jing After fune	Certification:	27. Manner of Death 1	28a. Date of Injur (Month, Day 28e. Place of Injur building, etc	Year)	28b. Time of Injury me, farm, str	М	Injury at Work? 1 Yes 2 N		(Street ar	nd Number or Rui	ral Route Number,
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Example one)	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, death ion and/or in	n occurred at t vestigation, in	ne time, date and my opinion, death	place, and due to the	cause(s	i) and manner as d place, and due	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	J. arle	, m	N		cense number	.11	29d. Da	ate signed (Month)	Day, Year)
4		30. Name and address of person who co	M.O.	eath (Item	23a) (Туре,	Print)	50.	39/15bil	4 1	no	
Sta Registr		31. Date liled (Month, Day, Year)	32. Registra	r's Signat	ure	e la	Al I				

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 9, Gary Edward 2005 May Doyle 3:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5728 Pindell Road Lothian Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 9, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1_MM 2□F 73 Director 579-40-6020 May West Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits in than "natural" or Itams 23a or 28a-f show the Medical Example must be notified at Maryland Anne Arundel Director 1 ☐ Yes 2 ☐ No Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with tond Mental Hygiene. Is marked other than "natural", or Itams 23a or ? 5728 Pindell Road 20711 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Ves 2 No 1951 If Yes, Give 1955 Year or Dates: 1055 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced 1955 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Lineman - Right of Way Pepco Energy Power Co. permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Doyle Sarah Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pollyann Doyle (wife) 5728 Pindell Road, Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 13, 2005 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /ani Cancer /Medical Due to (s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 1 Inpatient 3 DOA 5 X Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. escribe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fr death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41816 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Phelps, MD 139 Old Solomons Island Rd. Annapolis, Md. 21401 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

			1 - For State Registrar	State of M		id / Depa		of He	ealth ar	nd Me	R	iene	105	15863
	Physici	an	1. Decedent's Name (First, Middle, Li	ast)						2	. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Elina	F.			Domi	ngue	ez		May		005	5:00 a ^M
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, T	own, or	Location of	Death		4c. Coun	ty of Death	1
			32 Williams D		- 41		Anna		LS If Under 24	4 Neo Le			e Aru	
	Funeral			Sex 7. Ag 1 ☐ M 2XXF		last birthday) Yrs.	Months			Min.	Month, Day	Year)	9. Birth	pplace (State or Foreign untry)
	Director		578-02-1509 Usual Residence of Decedent		87					עו	ec. 7,	191/	Spa	in
	/land low		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation			-				10d. Inside City Limits
	Man 1-1 st	to	MD Anne	Arundel		Annapo	olis						ĺ	1 ☐ Yes ANO
	h the	irec	10e. Street and Number				10f. Zip (Code			1	0g. Citizen o	f What Cou	untry?
	th wit	alD	2 Chelsea Court					214	¥03			U	SA	
	within 72 hours after death with the Maryland ene. then "naturel", or Itams 23a or 28a-f show the Modical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	,	.S. 13.	Was Decede	ent of His	spanic Origin	n? (Speci	fy Yes or No- can, etc.)		ace - Amer ack, White	ican Indian,
36	or it	Y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🗶 If Yes, Give	No	- 1	1 ⊠ Yes 2						ify: Wh	
21215-0036	hours urel',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:						bpar				
5	"nat	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done d	tion u <i>ring m</i> ost o	of working		16b. Kind of	Business/l	ndustry
12	within Bna. then	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)		ditor	10(1100)				Modd	1 m	
d 2	filed with Hygiena. sther thei		17. Father's Name (First, Middle, Las	it)		1,0	1101		18. Mother's	s Name (First, Middle, i		cal T	ext
an	ould ba Mental arkad o	To Be	Oscar Dominguez						Tne	s Co	rra1		,	
Maryland	and Men Is marka	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address ((Street a			Route Number	; City or Tow	n, State, Zi	ip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene ittem 27 is marked other then "naturel", or Itams 23a or 28a-f show other traumatic event. The Madical Examiner must be natified at	0.5	Olga Dominguez	(Daughter)		32 7	Villia	ms I	rive.	Ann	apolis	MD 2	1401	
J.		1	20a. Method of Disposition		20b. F	Place of Dispo				Dat		20c. Location		own, State
Baltimore,	permit. Pagas Department of I Important: If its any injury or o		1 Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spec						1	9/20	05	Potom	ac. M	D
alt	permit. P Departme Importar any injur		21. Signature of Fogeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401											
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each li	d the deat ine.	th. Do not ent	ter the mode	of dying	, such as ca	ardiac or i	espiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Conge	Hiw	2 hec	Lit !	tai	lure)				Inset and Death
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Ð		-	Sequentially list conditions,	b. Horti	0	oteni	Sis						- 1	5 years
	pet nsit	ulu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01 as	a conseq	juence or).								
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68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit	ical	· ·	d										
.89	ifficat g phy as the			3.1										
Вох	leath certific attending p	/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Tratasia asa					23d. D	ate of deliv	very
	death	sicia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a			∃Ectopic pre ∃ Other (s <i>pe</i>					N	lonth	Day Year
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ord	w require been sign should b	ted	Claritonia	Motorche		104-01	0 8~			_	1 🗆 Y	es 2 No	3 ☐ Pro	bably 4 Tunknown
Records,	e law has b	Completed								_	24a. Was a autops	v l	prior to co	opsy findings available ompletion of cause of
HH		Co									perform		death?	2 🗆 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only on			Daughter's
ot	Phys this at di	. To	1 Yes 2 No 27. Manner of Death	1 L Inpatie		ER/Outpatier 28b. Time o		1	4 Li Iduis	sing Home	d. Describe ho	ence 6 🔼 O	ther (Speci	Daughter's Residence
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Division	of or Attend after death Director: /	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At h	ome, farm, st				_			nber or Rui	al Route Number,
ō	after after i Dire d in b	Certification:	4 Homicide determine	building, et	tc." (Speci	fy)					City or Town	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 ☐ Certifying F (Check only one)	Physician: To the best aminer: On the basis o and manner st	of examina	owledge, deat ation and/or in	h occurred a vestigation,	t the tim	e, date and inion, death	place, an	d due to the ca	ause(s) and r ate and place	nanner as	stated. to the cause(s)
	To th within To th compl	Me	206. Signalure and title of certifier	a. A.			29c.	License	number		2	9d. Date sign	ed (Month,	, Day, Year)
}	11		Mus A he	en IN			T	XI	030	3		5/i	OF	
1/	01		30. Name and address of person who	completed cause of o	death (Iter			<i>-</i> 15				7	~ ()	
l))	_	MARCO A. MESI	AMD 2	1002	MEL	SICAL	- Pi	ARKWI	AY #	310	ANNA	P, MD	21401
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Discretion Discre		/Medic	al	LEO F. J. 4a. Facility Name (If not institution, give	DOUGHE	RTY	-		Month HAY	Day Year OS 200 4c. County of De	95 9:30 AM
United Residence of December Incomment				5. Social Security Number 6. Se	PD		If Under 1 Year	If Under 24 Hr	. (Month. Da	th 9. B	irthplace (State or Foreign
Leo F. Dougherty, Sr. 19s. Informatic Name-Pastonship (Type Print) 19s. Mancod of Discostion - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Mancod of Discostion - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Mancod of Discostion - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Mancod of Discostion - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Mancod of Discostion - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Location - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Location - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Location - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 20s. Location - City or Town, State 1180.4 Parallel Road, Bowle, Maryland 20720 21. Signature of Fundy Special Road, Road Road Road Road Road Road Road Road		the Maryland 28a-f show	rector	10a. State 10b. County Maryland Montgome							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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Leo F. Dougherty, Sr. 19a. Identification State Ligis / Daughter 19b. Mailing Address (Sirea and Number or Rival Route Number Clayer Town, State Code) 18a. Identification State Ligis / Daughter 180. Maryland 20720 20b. Mailing of Ologopation State (Sirea and Number or Rival Route Number Clayer Town, State Code) 20b. Mailing of Ologopation State (Sirea and Number or Rival Route Number Clayer Town, State Code) 20b. Mailing of Ologopation State (Sirea and Number or Rival Route Number (Sirea and Number or Rival Route Number) 20c. Location City or Town, State May 10c. Location City or Town, State May 10c. Location City or Town, State Code) 20c. Location City or Town, State May 10c. Location City or Town, State May 10c. Location City or Town, State May 20c. Location City or Town, State May 10c. Location City or Town	00-61717	a within 72 hour jiene. r than "netural" ina Medical Ex		15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retire	during most of wo d)	orking	16b. Kind of Busines	s/Industry
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23. Signature of impured Speech (Speech) MO1305 22. Signature of impured Speech commendations that cause of each control of the speech of impured Speech control of the speech control of the speech of impured Speech control of the speech of impu	ָם פֿ	ges 1 and 2 s t of Health ar If item 27 is or other trau		Janet Ligis / Day 20a Method of Disposition	ighter 20b. F	11804 Place of Disposemetery, crem	Paralle sition (Name of natory or other pla	1 Road,	Bowie, Ma Date 11,	ary1and 20° 20c. Location - City o	720 r Town, State
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28. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death Check only one 27. Manner of Death Security Securi	E	/Medical ivacian and parial-transit	Icai	snock, or near failure. List only of the state of the sta	a. METAS) Due to (or as a conseq Due to (or as a conseq c.	uence of): F/L uence of):	er the mode of dying C LN M	ng, such as cardia	ic or respiratory ar PANCO	rest,	Interval Between
25. Was case referred to medical examiner? 1	.O. DOX	ine death certifi by the attending I ached for use as	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□		1			*
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 SAstural 1 SAstu	cords, r	been signed t		Part II. Other significant conditions on NORMAL PRES	ontributing to death but not res	ulting in the un DROC	derlying cause giv	ren in Part I. LUS	1 □ Y	es 2□No 3□P	robabiy 4 Onknown
Dawbane Relieving M.D. D 35436 MAY 08, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA KALAZNY HD, 6121 MONTROSE ROAD, ROCKVILLE, M.D. 20852		rtificate has	0					26. Place of De	autop perfor 1 ☐ Yes	sy prior to med? death? 2.□No 1 □ Ye	completion of cause of
Dawbane Relieving M.D. D 35436 MAY 08, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA KALAZNY HD, 6121 MONTROSE ROAD, ROCKVILLE, M.D. 20852	A 10 1101	ath. r: After this ce	P	1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur War	er: 4 A Tursing I y at k?	Home 5 Resid	ence 6 Other (Spe	ecify)
Dawbane Relieving M.D. D 35436 MAY 08, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA KALAZNY HD, 6121 MONTROSE ROAD, ROCKVILLE, M.D. 20852	אות מאות	urs after de ral Diracto	0	4 Homicide determined	building, etc. (Specify	v) 			City or Tow	n, State)	
Dawbane Relieving M.D. D 35436 MAY 08, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA KALAZNY HD, 6121 MONTROSE ROAD, ROCKVILLE, M.D. 20852		o the Fune	Medical	(Check only 2 Medical Exam	iner: On the basis of examina	wledge, death tion and/or inv	estigation, in my o	pinion, death occi	urred at the time, d	date and place, and du	e to the cause(s)
21 Date filed (Month Day Veed) 22 Decide to Cincil	J.Ł	1		· bawbane	Collecting completed gayse of death (Item	M. C.			6	MAY DS,	2005
State 31. Date filed (Month, Day, Year) 32. Registrar 32. Registrar 32. Registrar 33. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 33. Registrar 34. Date filed (Month, Day, Year) 32. Registrar 33. Date filed (Month, Day, Year) 33. Registrar 34. Date filed (Month, Day, Year) 33. Registrar 35. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar 35. Date filed (Month, Day, Year) 35. Registrar 35. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 37. Date filed (Month, Day, Year) 38. Date filed (Month, Day, Year) 39. Date	۷,		te	BARBARA KAL 31. Date filed (Month, Day, Year)	32. Regis ar's Signa		Godil	ISE ROAL	D, ROCKV	ILLE, M.	D 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 12A TMOL 6:10PM /Medical Facility Name (If not institution, give street and number) 4b. City. .Town, or Location of Death 4c. County of Death Examiner UMB JOW AR 0 UNT YWA If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Days Months Hours Min 1 M 2 X F 87 Yrs 513-20-8748 Director November 6, 1917 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neath of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Exercise must be notified at 1 Yes 2 No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 U.S.A 8455 Murphy Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than . Clerical Elementary/Secondary (0-12) College (1-4or 5+) Secretery is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Wilbainis Park Mabel Plearce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau P.O. Box 21169 Catonsville, Maryland 21228 Mr. Anthony Doyle Legal Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 05/09/2005 Baltimore, MD Bayview Crematory 21. Signature of Funeral SeA 22. Name and Address of Facility ice L) Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CRV /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 28b. Time of 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred After t Injury Matural 1 ☐ Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier death (Item 23a Type, Print) 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar		ryland / Dep <i>Ce</i>		Health and N	lental Hyg		005	15866
	Physici /Medio		1. Decedent's Name (First, Middle, Las Carl	F.	Froc			2. Date of Deat Month	9 ^{Day}	2005	3. Time of Death 12:00 PM
	Examir	ier	4a. Facility Name (If not institution, give 9 Deer Oak Court	street and number)		4b. City, Town, Phoeni	or Location of Death X			ounty of Death Altimor	
	Funeral Director		5. Social Security Number 218-54-0401 6. S Usual Residence of Decedent	7. Age XM 2 F 53	(In yrs. last birthday, Yrs.	Months Days		8. Date of Birth	952	9. Birth Co. Mar	nplace (State or Foreign unity) 'Yland
	Maryland	tor	10a. State 10b. County Maryland Balti	1	10c. City, Town or L Phoenix	ocation					10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 284	ai Direc	10e. Street and Number 9 Deer Oak Court			10f. Zip Code 211	31	10	Og. Citize	on of What Co	untry?
9800	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland sariment of Heelth and Mental Hygiene. sortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ioriant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event. The Medical Examinar must be positive at injury or other traumatic event. The Medical Examinar must be positive at a 2a.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 (2) No	Hispanic Origin? (Spoan, Mexican, Puerto Discourse Specify:	pecify Yes or No- Rican, etc.)		Race - Ame Black, White pecify: W	
21215-0036	filed within 72 h Hygiene, other than "natu ent, the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			dent's Usual Occu kind of work done DO NOT use retina ales Exe	pation a during most of work ad) CUTIVE	king		of Business/I	
Maryland	2 should be filed and Mental Hygie Is marked other raumatic event.	To Be C	17. Father's Name (First, Middle, Last) Carl F.		ock, Jr.		Cynthia			Brya	
	1 and 2 shi Heelth and em 27 is m		19a. Informant's Name/Relationship (1) Deborah M . Fro				t and Number or Rui Ourt, Phoe				ip Code)
Baltimore,	permit, Pages 1 a Department of He Important: If Iten any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cre Hilltop	osition (Name of matory or other pli Service	Corp. 5/13			ition - City or 1	
Bal	permit, Departr Importa any inji		21. Signature of an Al Service Licen	िया	₽	ack tows 050 York	Shoffumeral Rd., Tows	Home, I	nc. 2120)4	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
90,		i Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter of nonlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):						
P.O. Box 68760,	the death certificate by the attending phy ached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d. 23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	⊒Ectopic pregnand □ Other (specify)	Sy.		230	d. Date of delik	very Day Year
ecords, F	en signed l	by	Part II. Other significant conditions co	ontributing to death but	t not resulting in the u	nderlying cause g	ven in Part I.	23e. Did tob	_/		the cause of death?
α		Completed					·	24a. Was an autopsy perform	/	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of
f Vital	Physicien: Tribis certifical	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 ER/Outpatie	nt 3 DOA Ot	h	h <i>(Check only one</i> ome 5 ⊟ Resider		Other (Spec	(f ₁)
Division of	Attending Ph death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		f 28c. Inju		28d. Describe ho			
Divis	fter fter n b	Certification:	3 Suicide 6 Could not be determined	building, etc.				28f. Location (Str. City or Town,	State)		
	To the Hospital of within 24 hours at To the Funeral D completely filled i	Medical	29a. Certifier Certifying Phyone) Check only one)	/sician: To the best of iner: On the basis of e and manner state	examination and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the car red at the time, da	use(s) an te and pla	nd manner as ace, and due	stated, to the cause(s)
)	withi To 1	W	29b. Signature and title of certifier	allow,	MO		30929			signed (Month)	,
1) 'Q		Paul Celano, M.D.	completed cause of 6569	N. Charl	es Stree	t Suite 20)5, Towso	on, M	arylan	d
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 200	32. Registrar	's Signature	110					

			1 - For State Registrar	State of M	larylan	d / Depa		t of H	ealth a	and M	_		9	5	15	867
	Physici	an	Decedent's Name (First, Middle, I	,							2. Date of De Month	ath Day	Yea		. Time o	f Death
	/Media	cai	Walter E. Farre		-1		4h Cit.	T	Lanting		May 3,	2005		1	:06	_ P M
	Examir	ier	Montgomery Gener		,				Location of	of Death			ounty of De			
	Funeral			Sex 7. A	ge (In yrs.	last birthday)	01n	1 Year	If Under		8. Date of Bir (Month, Da		ntgome 9. E		(State	or Foreign
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	or 28s	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citize	n of What	Country?		
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Maryland	2 should be and Mental Is marked (sumatic ev		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City or 7	оwп, State	, Zip Cod	fe)	
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altimore,	ages 1 au nt of Hea : If item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. P	lace of Dispo emetery, crer Montgo	sition (Nar. natory or o Merv	ne of ther place) 1	May 8	8,	20c. Loca	tion - City o	or Town,	State	
Itin	permit. Pages . Department of H Important: If Ite any injury or ot		* 4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Cre	matori	um,	nc.		2005	ort A	Bethe	sda,	Mary	land	1 /
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of	Physic this cral direct	. To	1 ☐ Yes 2🛣 No 27. Manner of Death	Hospital:		ER/Outpatien			4 🗀 Nur		ne 5 Resid			ecify)		
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. 1	1	-	20 Name and 111			WID		35635	, 			мау Е	3, 200	75		
13			30. Name and address of person who Joseph Kaplan, M.	D., 18111	Princ	e Phi	lin D	rivo	015	037	Maryle-	പാവ	222			
	Sta	te	31. Date filed (Month, Day, Year)	1 2005 3 2. Regis	ar's Signat	ture H	free	LIVE,	, OTII	cy,	rary Lan	ia ZUč	52			
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FOLDE RAUGE, MYRTLE Baltimore, Maryland 21215-0036

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		For	State of Mar	-			Mental Hyg	iene				
		1 - State Registrar		Ce	ertificate of	Death		eg. No.)		5.0	5.0	
Physic	cian	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Voor	Time of D		
/Mec			S.	FOLDER.		.1	5	4c. County of		:50	Ам	
Exam	iner	4a. Facility Name (If not institution, give: FRANKLIN SQUARE		CENTER	Ro	SEDALE		BA	CTIMOR			
Funera Directo		5. Social Security Number 6. Sec 214 16 3010	7. Age ((In yrs. last birthda 83 Yrs.	y) If Under 1 Year Months Days	Hours Min.		1922	9. Birthplace (Country) MARYL	(State or F AND	Foreign	
		Usual Residence of Decedent		10 - 01 - T					104 1	anida Cita	Limita	
show	1-	10a. State 10b. County		10c. City, Town or						nside City		
ith the Ma or 28a-f	5	MD BALTIMO	RE	NOTTI			Т.					
vith th	F	10e. Street and Number 16 LESLIE AVEN	(IF		10f. Zip Code 21 23 6			0g. Citizen of W USA	nat Country?			
sath v	erai		12. Was Decedent Ev	er in U.S. 13	3. Was Decedent of H		Specify Yes or No-		- American In	idian,		
iter d	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 No		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		, White, etc.	_		
urs a urs a all', o	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	WHIT	E		
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Per Per Per Per Per Per Per Per Per Per	du	Elementary/Secondary (0-12)	College (1-4or 5+)	1	. DO NOT use retire CRETARY	d)		BALTO	י רדיי	v sc	СНООІ	
lled w Hygier her th		1 2 17. Father's Name (First, Middle, Last)	0	0.10	CKBIMKI	18 Mother's Na	me (First, Middle,					
I E. INICITY ICALICAL 2-00030 s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shou other traumatic event, the Medical Examinational be notified at	o Be		OTT			MYRT		THICUM				
should be nd Mental marked o	2	19a. Informant's Name/Relationship (T)		19b. Ma	iling Address (Street	and Number or Ri	ural Route Number	r, City or Town, S	State, Zip Code	Θ)		
e, IVIC		LYNNE F. WILMER	/ DAUGH	TER 16	LESLIE	AVENUE	BALTIMO	RE, MD	21236			
es 1 ac of Hea of Hear of Item		20a. Method of Disposition	Chata	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location - (City or Town, S	State		
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DESILTINGS permit. Pages Department of Important: If It any injury or or	DUCE	21. Signature of Funeral Service Licens	le .		22. Name and Addre 1211 CHE			SEDALE SIMORE,				
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ON C ding P h. After t funera	on:	27. Man or of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wo	iry at ork?]Yes 2 □ No	28d. Describe h	ow injury occurre	ed .			
ISIO Ntendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	ov - At home farm	street, factory, office		28f. Location (S	treet and Numbe	er or Rural Rou	ute Numbi	er.	
DIVISION For Attending after death. Director: After in by the fune	ertification:	4 Homicide determined	building, etc.		street, factory, office		City or Tow					
spita ours seral	edicai C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of iner: On the basis of e	examination and/or	eath occurred at the trinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the c urred at the time, c	cause(s) and mai date and place, a	nner as stated. Ind due to the	cause(s)		
o the Hos ithin 24 h o the Fur ompletely	Med	one) 29b. Signature and title of certifier	and manner state	ou.	29c. Licen	se number		29d. Date signed	(Month, Day,	Year)		
H S H	1	1 14,00,2	Killen	ui -	100	00 614	18	5191	05			
TU	Andrew Control	30. Name and address of pason who o	ompleted cause of de	ath (Item 23a) (Typ	pe, Print)	7-1						
10		Kelly L. Miller	3 M.D.	7000 FRAT	MKLIN SQU	IAR:E DRI	VE, BAC	TIMORE	MD	213	.37	
15	State strar	31. Date filed (Month, Day, Year)	2005 Section	u Signatur	400							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Willie Foulks 14142 M Mai 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jessup Howard 8327 Wades Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 60 Yrs 249-70-6887 **Director** September 13, 1944 South Carolina Usual Residence of Decedent 10c. City, Town or Location r 28a-f show 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Howard Jessup 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or U.S.A 20794 8327 Wades Way death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Etn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after 1 Never Married 2 Married i Ethan Maryland 21215-0036 1 ☐ Yes 2 🗙 No þ Specify. Specify Black 3 Widowed 4 Divorced Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Parks & Planning Commision the Ma other then Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 17 is marked c traumatic eve James Eddie Foulks Alma Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any injury or other trau 9141 Gracious End Ct. Unit 202 Columbia, Maryland 21046 Ms. Lillian Street-Augutus Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/10/2005 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) **Bayview Crematory** 21. Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a, Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastroin /Medical **Examiner** Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner physicien and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown been si should I Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 46 has e 2 s certificate ha 1 Yes 2 14 No Be director 25. Was case referred to medical 26. Place of Death Check on one Other: 4 ☐ Nursing Home 5 i esidence 6 ☐ Other (Specify) Hospital: 1 Xes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check or one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) May 10, 2005 30. Name and address of person who come ted cause of death (Item 23a) (Type, Print) PA Toye, Patryce A AND Dep. Med Ex 4565 Hentlock GonelWay Ellicott City, MD 21048 Mb 21842 31. Date filed (Month, Day, Year) State MAY 1 1 2005 Registrar

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	Physici		Terrence Er									MAY 4	2005	Year	4:02 P M
	/Medic Examin		4a. Facility Name (If not			ber)		4b. City,	Town, or	Location of	of Death			unty of Death	
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	Funeral		5. Social Security Number			'. Age (In yrs.	last birthday)			If Under Hours		8. Date of Bir (Month, Da	th (Year)	9. Birth	place (State or Foreign ntry)
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03	ral', c	t by	3 ☐ Widowed 4 ☐ I	Divorced	Year or Da	les:		1 🗌 Yes	2 ga No	Specify:			Sp	e <i>cify:</i> Whit	te
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Σ	od 2 alth ar		Melanie Gei	.man			282	Winte	rber	ry La	ne W	estmins	ster,	MD 211	57
ē,	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumetic		20a. Method of Disposition				Place of Dispo cometery, crea	sition (Nar	ne of	-	D	ate		ion - City or T	
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Вох	nding use a	an/Med	IF FEMALE: 23b. Was decedent pred	gnant	23c. If yes, outo			7e					23d.	Date of deliv	ery
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ord	w require been sign should b											1 🗆 '	Yes 2 N	o 3□Pro	bably 4 □Unknown
ecc	e law r has be je 2 sh	ple										24a. Was	osv	prior to co	opsy findings available ompletion of cause of
m m		Completed										perfo	rmed? 2 ☐ No	death?	2□ No
Division of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to examiner?	o medical							of Death	(Check only o	one)		
5	Physi this c al dire	은	Y Yes 2 No				ER/Outpatier			4 L NU		ne 5 Resi			
n c	ing F	lon		Pending	1 1	Day Year)	28b. Time o Injury	т 2 Дм	8c. Injury Work	?		nvolved i			ver of valuelle
Sic	Attending r death. ector: Afte	icat	2 Accident 3 ☐ Suicide 6 [investigation Could not be	2/4/62	of Injury - At he	3108		1 🗆 Y	res 2 X		Of Location (Ctront and M	umbas as Dus	al Route Number,
\leq	7 8 T C	Certification:	4 Homicide	determined	buildin	g, etc. (Specif	y) / /	eet, ractory	, office			City or To	vn, State)	-83 N	Ba Gold
_	pital		29a. Certifier 1	Certifying Ph	ysician: To the b	est of my kno		b occurred	at the tim	a data an	-	fille hi	Dil	Traguet	, 4999.
	e Hospital of 24 hours af e Funerel Dietely filled in	edical	(Check only 2 X	Medical Exan	niner: On the bas	sis of examina	tion and/or in	vestigation	, in my op	oinion, dea	th occurre	ed at the time,	date and pla	ce, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	of certifier				290	. License	number			29d. Date si	gned (Month,	Day, Year)
}		}	+ Hanset	Grith	holl m	Λ			OC	ME			MAY 5	, 2005	
	1/1/		30. Name and address	of person who	completed cause	of death (Iten	n 23a) (Type,	Print)		-2-0	-				-//-
	41		Pamela E.	Southa	1, MD				Penn	Stre	eet	Baltimo	ore, M	arylan	d 21201
	Sta		31. Date filed (Month, Da	ay, Year) -	- 47	gįstrar's Signa		4							
	Registr	ar	MA	Y 112	005	due ,	15 A	make							
DH	MH 17 Rev 1/2	001			100		1								

			1 - For State Registrar	State of Maryland /		ment of Health		l Hygier Reg. 1	711115	15871
	hysicia /Medic		1. Decedent's Name (First, Middle, Last)		rar	di	Mod	4 0	Pay Year	3. Time of Death
E	xamin	er	4a. Facility Name (If not institution, give s River View Care C		46	. City, Town, or Location ESSEX	on of Death	'	ac. County of Death Baltimor	
	neral ector		213-30-4330	7. Age (In yrs. last b		Under 1 Year If Und onths Days Hour	der 24 Hrs. 8. Date rs Min. Dece	of Birth oth, Day, Yes mber 3	9. Birth 81,1938 No	nplace (State or Foreign untry) EW York
Maryland	a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore Ess	own or Location	on				10d. Inside City Limits 1, Yes 2 □ No
with the	a or 28 Lbe not	Director	10e. Street and Number 1 Eastern Blvd.		1	Of. Zip Code 21221			Citizen of What Col ISA	untry?
s after death	or Items 23 aminer mus	y Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1.☐ Yes 2 ☐ No If Yes, Give	If Ye	Decedent of Hispanic s, specify Cuban, Mexi Yes 2 No Spec	ican, Puerto Rican, e	s or No-	14. Race - Amer Black, White	o, etc.
IIIG Z I Z I 35-0030 be filed within 72 hours after death with the Maryland ital Hygiene.	itam 27 is marked othar than "natural", or flems 23a or 28a-f show other traumatic event. The Medical Examener must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edur (Specify only highest grade Elementapy/Secondary (0-12)	College (1-4or 5+)	(Give kind life. DO l	s Usual Occupation of work done during n NOT use retired)	nost of working		Kind of Business/I	
nd Al	d othar th	Be Con	12th 17. Father's Name (First, Middle, Last) Austin Richard G		Mainte	18. Mc	other's Name (First,	Middle, Maid		Apartments
aryla should t	marke	၉	19a. Informant's Name/Relationship (Ty)		9b. Mailing A	ddress (Street and Nur	<u>-</u>	Neary Number, Cit	y or Town, State, Z	ip Code)
e, Mic	im 27 is her trau		Patricia Knight	(Sister) 15	529 Fr	enchtown R	oad Perry		MD 21903 Location - City or 1	
altimore mit. Pages 1 partment of H	Important: If itam 2 any injury or other QDCB.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemet	tery, cremato	ical Schoo]		shington	
Salti Dermit.	Importa any inju once.		21. Signature of Funeral Service Licens		22. X	USEIN ROYS	ter Funer	al Hom	e	
			23a. Part1. Enfer the disease, or complishock, or heart failure. List only or	cations that caused the death. Do	o not enter th	821 14 St. e mode of dying, such	as cardiac or respir	ngton, atory arrest,		Approximate Interval Between Onset and Death
/Me	dican dical niner		disease or condition resulting in death)	Due to (or as a consequence	e of):	/ / / / / /				un- Known
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):					
8/0U, ate be executed	ıysician and ne burial-tra	dicai Exar	that initiated events resulting in death) Last	Due to (or as a consequence	e of):		-			
ecords, P.O. Box 687 law requires that the death certificate	certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		opic pregnancy ner (specify)			23d. Date of deli	very Day Year
dS, P.	signed by Id be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting	in the under	lying cause given in Pa	90At 23	e. Did tobacc		the cause of death?
Kecords, The law requires	ate has beer page 2 shou	ompleted	Sezure D	rbader.	Ure	Glenny S		a. Was an autopsy performed'	prior to c death?	topsy findings available ompletion of cause of
VITAI sician: 1	is certifica director, I	o Be C	25. Was case referred to medical examiner?	lospital:	2	0.1	lace of Death (Check		2 □0ther (0and	
VISION OT VITA Attending Physician: r death.	To the Funaral Director: After this completely filled in by the funeral dir	F	27. Manner of Death Natural 5 Pending 2 Accident investigation		o. Time of Injury	28c. Injury at Work? M 1 Yes 2	28d. De		njury occurred	uy)
DIVISION al or Attending s after death.	al Director ad in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office	28f. Loc City	ation (Street or Town, St	and Number or Ru ate)	ral Route Number,
L ne Hospital n 24 hours a	se Funara detely filk	Medical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sicien: To the best of my knowled ner: On the basis of examination a and manner stated.	lge, death oc and/or invest	curred at the time, date gation, in my opinion, o	and place, and due death occurred at th	to the cause e time, date a	o(s) and manner as and place, and due	stated. to the cause(s)
To the	To tl	Ž	29b. Signature and title of certifier	M-D		29c. License numb	8754		Date signed (Month) 4-04	n, Day, Year) -2005
			10 (1) = (()	ASCEM. 7	109.	BASTB	RN BL	ND	-MD.	2/221
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 1	32. Registrar's Signature	K A	sell .				

b-	•		For State Registrar	State of Maryland		artment of Hea			ne No.2005	15872
	, it		Decedent's Name (First, Middle, Last,)				Date of Death		3. Time of Death
	Physicia		Joseph	Haase					Day Year 9 2005	2:13 PM
7	/Medic	_	4a. Facility Name (If not institution, give			4b. City, Town, or Loc		1	4c. County of Dea	
1	Examin	er		pital		Randall	1		Balt	6.
	Formation		5. Social Security Number 6. Se	7. Age (In yrs. las	st birthday)	If Under 1 Year If	Under 24 Hrs. 8.	Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		220-76-9954	20F 59	Yrs.	Months Days H	lours Min.	(Month, Day, Ye	1511 C	ountry) MA
			Usual Residence of Decedent						793	
	/lanc		10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Man -fah	ţŏ	MD NA		Par	Kuille				1 Yes 2 No
	1 the	rec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	3a o	0	4204 WOEDS	tock Ave		212	06		U.S.A	
	ns 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Specify	Yes or No-	14. Race - Am	
10	r ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		_		an, etc.)	Black, Whi	te, etc.
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No S	Specify:		Specify: Li	h.te
21215-0036	within 72 hours atter death with the Maryland ene. than "netural", or items 23a or 28a-f ahow the Maulcal Excreting in the motified at	Completed by	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupation kind of work done during	n na most of working	165	. Kind of Business	/Industry
215	hin 7	ğ	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired)	0		1/2	
21	filed with Hygiene. ther than	5	NA	NA		never a	JORKEN		NIA	
p	e filed al Hygie I other vent, II	Be (17. Father's Name (First, Middle, Last)			18.	. Mother's Name (Fi	_	den Sumame)	
<u>ja</u>	Mental arked o	ဥ	William HAA:	se			LYDIA	PRICE		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at the notified at ance.	i d	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street and				
_	and 2 lealth m 27 i	1 38	ANNA Lynch		330	c Morthwa	44 DR. 1.	3Alto V	M 2123	4
ore	of He of He fitan roth		20a. Method of Disposition	20b. Pla	ce of Disponentery, cre	osition (Name of matory or other place)	Date		. Location - City or	
Ĕ	Page Pent of		1 Burial 2 ☐ Cremation 3 ☐ F 1 Donation 5 ☐ Other (Specify)	Poni	Lucci	cem	3/4/	5 B	16-M	1.
Baltimore,	permil. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		2:	2. Name and Address of	f Facility	a Gunea	al ktome	
ä	Depar Impo any ir		Dave M -	ble	H	ARTICY MILLS	17527 ha	FOLD &	D. Bolto	MO 21234
			23a. Part1. Enter the disease, or comp	lications that caused the death.	Do not en	ter the mode of dying, s	uch as cardiac or re	spiratory arrest,		Approximate Interval Between
	Physician	a	shock, or heert failure. List only o	44 Direct		-d - f	Lune			Onset and Death
1	/Medical		disease or condition resulting in death)	a. Multiple org		system ta	IIUIO			>24 hours
	Examiner		The second secon	Acute respi	cato	ry failur	2			> 48 hours
		ē	if any, leading to immediate	b. Due to (or as a conseque	nce of):					10 10003
	uted	Ē.	cause. Enter Underlying Cause (Disease or injury that initiated events	· Aspiration	pp	eu monia				> 3 days
,	be executed sictan and burial-transit	Examin	resulting in death) Last	Due to (or as a conseque						
760,	Ihat the death certificate be execu ed by the attending physician and detached for use as the buriat-tra	cai		d						
89										
Вох	ndin use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		75			23d. Date of de	livery
m	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		□Ectopic pregnancy □ Other (s <i>pecify</i>)			Month	Day Year
P.O.	requires that the death certifica een signed by the attending ph hould be detached for use as th	ys	9 Unknown	9 Unknown					1	
	ihat hed b	γP	Part II. Other significant conditions co	ntributing to death but not result	ting in the u	inderlying cause given in	n Part I.	23e. Did tobac	co use contribute t	o the cause of death?
S p.	uires na sign	d b	Gastrointestinal	hemorrhage	ر			1 🗆 Yes	2 1 No 3 □ P	robably 4 Unknown
Ö	> 0 0	lete	Clostridium diffic	ile colitis				24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	e la has	Completed by Physician/Med						autopsy performed	?? death?	
a	iclan: Th certificate rector, pag		Mental retardati	on				1 Yes 2 ¥	No 1□Ye	s 2 □ No
Σ		Be	25. Was case referred to medical examiner?	Hospital:	D/O	Other	3. Place of Death (C		- 0 DOH(0-	
of	Phys this ral di	٠ <u>.</u>	1 ☐ Yes 2 ② No 27. Manper of Death		R/Outpatie 28b. Time o	nt 3 DOA	4 Nursing Home 28d	. Describe how i		эспу)
LO C	tending Ph leath. tor: After th the funeral	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work?	: 2 □ No			
Si	deat deat ctor: / the	lica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne. farm. st	reet, factory, office	28f.	Location (Stree	t and Number or R	ural Route Number,
Division of Vital Records,	or A after Dira	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		,,		City or Town, S	tate)	
	To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	O .	29a. Certifier 1 Certifying Phy	sicien: To the best of my know	ledge, deat	h occurred at the time.	date and place, and	due to the caus	e(s) and manner a	s stated.
	24 h 24 h e Fur etely	edical	(Check only 2 Medical Exem one)	iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my opinio	on, death occurred a	at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License nu	umber	29d.	Date signed (Mon	th. Day, Year)
	~ S F 0	/	1 2 Booton	MO		D2846	52	A	pril 29,	2005
1	10/		30. Name and address of person who o	ompleted cause of death (Item 5	23a) (Tvne			i	/	
1	11.			Vorthwest Ho	spita	11 Center	Randa	Ustown	n. Marvi	and
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sonatu	ire	4 1 W.	. 4 - 11 1 1 1 1 1 1 1		/	
	Regist		MAY	ompleted cause of death (Item a Northwest Ho	100	T. Popular				

			State of Maryland / Depa		ental Hygie	ene					
			1 togration	rtificate of Death	Rag 2. Date of Death	. No. 0 . 0 . 5	15070				
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year	3. Time of Death				
	/Medic	al	Ruth Read Hopkins 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 10,	2005 4c. County of Death	17:20 A "				
	Examin	er	Gilchrist Center			-					
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	TOWSON If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimon 9. Birth					
	Funeral Director		220-34-5087 1 M 2X F 98 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 19		place (State or Foreign intry) Maryland				
_		Ì	Usual Residence of Decedent		Uhrtr 1	, 1247					
	nylan how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits				
	Ba-fa	cto	MD Baltimore Towson				1 ☐ Yes 2 ☑ No				
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	intry?				
	ath w		113 Yorkleigh Road	21204		United St					
	er de	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow he Medical Eraninan raatke nedilied at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	White				
Ş	hour	ed t	^	dent's Usual Occupation	16	b. Kind of Business/l	ndustry				
5	In 72 n na nedic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of workin DO NOT use retired)	g		,				
212	iene.	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 T	eacher		Educatio	ın				
힏	e filec I Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma						
<u>a</u>	ould be filed v I Mental Hygie tarked other t tatic event, In	To E	Nathaniel Read	Adeline	Richar	ds					
=	듀얼트트			ng Address (Street and Number or Rura)			ip Code)				
Σ.	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ia marke any injury or other traumatic once.			4 E. Lombard Stree			21 2 31				
ltimore,	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Damatory or other place)	ate 20	c. Location - City or 1	own, State				
Ē	Pag ment ant:		`4 ☐Donation 5 ☐ Other (Specify) Loudon Pa	rk Cemetery 05/14,		Baltimore,					
Bail	epart epart nport ny in						Home, Inc.				
_	0.0 ± € 0	_	Stephen Coster	1050 York Road,			21204				
Ц			23a. Part 7. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest	t,	Approximate Interval Between Onset and Death				
	Priysician	Immediate Cause (Final disease or condition resulting in death) a									
	/Medical Examiner		Due to (or as a consequence of):								
		<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
	ted nsit	듣	Cause. Cher Underlying Cause (Lisses or injury that initiated events c.								
	al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760	cate be executed obysician and the burial-transit	dical	d								
89	ificati g phy as the	0			0.000						
Вох	eath certific attending p I for use as	N/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	∃Ectopic pregnancy		23d. Date of deli	•				
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/M		Other (specify)		Month	Day Year				
Ö.	that the de ned by the a detached f	h'S	9 Unknown								
Records, P.	res tha igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		cco use contribute to					
ord	w requir been si should	ted			1 Tes	2 □ No 3 □ Pro	Dably 4 Conknown				
ecc	ne law r has be ge 2 sh	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of				
<u> </u>	The cate h	ပ္ပ			performe 1 □ Yes 20		2 □ No				
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		1				
of o	Physic this c	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o		ne 5 Residence 8d. Describe how		ity) NOTPLY				
D D	ding F h. After funer	lon	Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	ou. Describe now	injury accurred					
<u>s</u>	lor Attand after death Director: /	ical	2 Accident investigation 3 Suicide 6 Could not be determined edge.		8f. Location (Stree	et and Number or Ru	ral Route Number,				
Division of Vital	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)					
	spita nours neral		29a. Certifier Certifying Physician: To the best of my knowledge, deat								
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one) (2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date	e and place, and due	to the cause(s)				
	To the training of training of the training of the training of the training of trainin	E	29b. Signature and title of certifier	29c. License number		I. Date signed (Month					
)	111		Menon	N 28303		vious 10	~UJ				
	15		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) - Chenles St	Balt	more un	21204				
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	• 0			J				
\$-	Regist		31, Date filed (Month, Day, Year) MAY 1 1 2005								

			1 - For State Registrar	e of Maryland / Depa <i>Cer</i>	rtment of Hea tificate of De		ntal Hygien Reg. N	000	7 10071
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) HARRY HUDG	INS		1		ay Year	3. Time of Death
	Examin	er		PITAL CENTER		LLSTOW	7,0	BALTI	more
	Funeral Director		5. Social Security Number 216 07 9829 Usual Residence of Decedent	7. Age (In yrs. last birthday) F 89 Yrs.		Under 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Yea. June 5 1915	9. Bin Balt	hplace (State or Foreign buntry) Cimore, Mary land
	Maryland -f show lied at	tor	10a. State 10b. County Maryland Baltimore	10c. City, Town or Loc Baltimore Co					10d. Inside City Limits 1 Yes 2 No
	or 28a	Funeral Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	puntry?
	s 23a	rail	6825 Campfield Road Apt. 1		21207			SA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	by	1 Never Married 2 Married 1 1	ed Forces? If Yes 2 ☐ No	Vas Decedent of Hispar Yes, specify Cuban, M ☐ Yes 2∏ No Si	nic Origin? (Specify lexican, Puerto Ric pecify:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within 72 ho lene. than "natur he Medical	Completed		eted) (Give I	ent's Usual Occupation kind of work done durin OO NOT use retired)	g most of working		Kind of Business	,
	e filed v al Hygie other t vent, in		17. Father's Name (First, Middle, Last)	Figure		Mother's Name (F		nstruction n Sumame)	
Maryland	ould be Mental Marked o	To Be	Harry Hudgins		Ve	ernona Wri	oht		
fary	2 should be and Mental Is marked raumatic ev		19a. Informant's Name/Relationship (Type, Prin		g Address (Street and I	Number or Rural R	oute Number, City		,
	s 1 and 2 of Health a item 27 ls other trai	7	Norine Hudgins (Wife) 20a. Method of Disposition	20b. Place of Dispos	ampfield Road	1 Apt. 1	C Baltimo	ce, Maryla Location - City or	
Mor	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	atory or other place) m. Park Cem.	 Mbsz 11 200		timere.Mar	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	Ì	21. Signature of Funeral Service Licensee	. 22.	Name and Address of ASSAN Funeral	Facility		- LILL 91 FIL	y Iza C
8	99729		23a. Part1. Enter the disease, or complications				re. Marvla	nd 21236	
	Physician /Medical		23a. Part : Enter the disease, or complications shock, or heart failure. List only one caust Immediate Cause (Final disease or condition resulting in death)	PARKINSON	DISEASE	ich as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Examiner		Di	ue to (or as a consequence of):					
	P =	iner	cause. Enter Underlying	ue to (or as a consequence of):			-		
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):		· · · · · · · · · · · · · · · · · · ·			
8760,	icate be executed physician and s the burial-transit		L _d .						
9	rtificati ng phy as the	Medic	IF FEMALE:						
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)	· ·		23d. Date of del Month	ivery Day Year
<u>α</u>	es De		Part II. Other significant conditions contributing		, ,	Part I.	23e. Did tobacco		the cause of death?
of Vital Records,	0 5 0	Completed by					24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	V		Place of Death (C			
of	ys Sign	- To	1 Yes 2 No Hospital:	1 Date of Injury 28b. Time of		Nursing Home	5 Residence Describe how inj		cify)
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Division	200>	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f.	Location (Street a City or Town, Sta		ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examiner: On	To the best of my knowledge, death the basis of examination and/or inv I manner stated.	estigation, in my opinio	n, death occurred a	at the time, date ar	nd place, and due	to the cause(s)
)	To T com	Σ	29b. Signature and title at certifier		29c License nur	2783	MA		2005
	1841		HVVERALFALLI	d cause of death (Item 23a) (Type, F	Print) NORTH 5401	WEST	HOSPIT	ALMDE	21133
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 2005	39 Registrar's Signature	W				

. , ,	.0		1- State of Maryland / Department of Health and Certificate of Death		giene Reg. No.2	005	5	375
	Dhuoisi	o 10	1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	Vear	3. Time of	Death
	Physici /Medic		Bonnie Janine Hurlbut	APRIL	27, 20	05	0600	ам
) 	Examin	er	4a. Facility Name (If not institution, give street and number) I 95 SOUTHBOUND @ 82.4 MILE MARKER 4b. City, Town, or Location of Deat ABERDEEN	h	4c. Cour HARE	TORD		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 217-60-2050 1 Months Days Hours Min.	(Month, Da	y, Year)	9. Birthp	lace (State o	r Foreign
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	hours after death with the Maryland lurel, or llems 23e or 28a-f show al Exandrat must be rediffed at		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside Ci	ty Limits
	Maried st	tor	MD Cecil Conowingo				1 🗌 Yes	2 X No
	or 28)ire	10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Cour	itry?	
	ath with the Marylar s 23e or 28e-f show	ral	115 East Red Hill Road 21918		USA			
	Items	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No to Rican, etc.)		ace - Americ lack, White,		
30	hours aft lurel', or l	by F	1 X Never Married 2 Married 1		Spec	ify: WL	ite	
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دا2 15	hin 7	piet	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) (Give kind of work done during most of working most o	rking				
7	s filed within 72 I Hygiene. other than "nei /ent, in the Media	Completed	2 years Medical Driver		County	y Gov	ernme	nt
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<u>Xa</u>		٦		Ann Puc				
<u>aa</u>	30 30		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rt				~	1078
	es 1 and 2 of Health filem 27 r other tra		Mary Ann Brinegar- Mother 40 Robinhood Rd., Book Method of Disposition (Name of	ox 713,	Havre 20c. Location			MD
ğ			1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	0./0=			wii, State	
altımore,	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	-	Dublin			
n	Depi Impo	0	Mitchell-Smith Fund	eral Hom	ne, P.A	١.	4D 210	.70
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar			ace, N	Approximate	9
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ב	ing Ph Viter th uneral	OU:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Works	28d. Describe h	now injury occi	urred	- 0.	
<u>s</u>	Vitendi death. ctor: A y the fu	cat	Accident investigation 1 1 1 1 1 1 1 1 1	mver 6	fran	strick	Inct	
DIVISION OF	nl or Attending P after death. I Director: After d in by the funera	ertification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S	Street and Nun	Der or Hura	I Houte Numi	oer,
_	To the Hospital or Attending Physicien: To the Funeral Director: After this certific completely filled in by the funeral director,	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, leath occurred at the time, date and place	and due to the	SUSPECT STATE) Co	meles	· wice
	e Hos 24 h e Fur	edicai	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the time,	date and place	, and due to	the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier 29c. License number		29d. Date sign			
			OCME OCME		APRIL	27, 20	005	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
_	10		JAPON OUT IN 111 PENN STREET, BALTIMO	RE, MARY	LAND 2	1201		
	Sta		31. Date filed (MMAAAV, Year) 2005 Registrar's Signifiere					
	Registr	ar						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 April 28, **Physician** John Stoner Haller 3:25 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 23, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** . Year 920 1**X** M 2□ F Months 213-16-1416 85 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Examinations of the process. 10a. State 10h Counts 10c. City Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 East Third Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give 1 043–1945 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White φ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Power Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Fessler Haller Marie Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lavinia M. Haller, wife 17 East Third Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

→ Burial 2 □ Cremation 3 □ Removal from State Date Mount Olivet Cemetery May 2, 2005 Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 | 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encephalopathy **Physician** 1 Day /Medical Due to (or as a consequence of): Examiner **CVA** 1 Dav Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? (es 2X No this certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Chack only one) and manner stated 29b. Signat and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 36421 May 5, 2005 Menny 30. Name Address of person who completed cause of death (Item 23a) (Type, Print) James P. Amerena, M.D., 9093 Ridgefield Dr., Suite 104, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registra Signature State MAY 1 1 2005 Registrar

			1 - For State Registrar	State of M	arylan	d / Depa	artme		ealth a) 5	5	377
7			Decedent's Name (First, Middle, La	ast)			_	-			2. Date of De.			Year	3. Time o	of Death
	Physici /Media		John Edward Hi	sley, Jr.							May 4,	200	Š5	1981	10:37	а м
	Examir		4a. Facility Name (If not institution, gir	ve street and number)			4b. Cit	y, Town, or	Location of	Death		4c.	County	of Deeth		
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	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f show ther than "natural" or Items 12a mullied at Int, Ite Mudical Examinat remailed at	ğ	Md. Harf	ord				Air								s 2 No
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ore	of He		20a. Method of Disposition	78		lace of Dispo	sition (N	ame of	9)	Da	te	20c. Lo	ocation -	City or To	own, State	
Baltimore,	Pag ment ant: h		1 ⊠ Bunal 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special			ered H			1	em 5/	7/05	Dunc	lalk	, Md	•	
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of	g Phy er thi		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		28c. Injury	at		ld. Describe I				<u>y)</u>	
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			For State Registrar	State of M	Marylan		artment of H tificate of L		d Mental Hy	giene 0	05	158	378
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	Funeral Director		707 17 0720	x	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h	lin. 8. Date of Birt (Month, Da September	h y, _{Year)} r 6, 1923	9. Birthp Coun Texa	lace (State or htry) S	r Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside Cit	ty Limits
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	or 28s)irec	10e. Street and Number	•			10f. Zip Code			10g. Citizen of		•	
	ath wi	ral	3503 Fiske Terrac				2090			United			
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Medical Exactiner must be rotified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? X No	'	Was Decedent of Hi f Yes, specify Cubai I X Yes 2 ☐ No		(Specify Yes or No Jerto Rican, etc.) (exican		ice - Americ ack, White, ify: Whi	etc.	
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Baltimore,	Pages 1 and 3 nent of Health int: If itam 27 iry or othar tru		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from Sta	te C	Place of Dispo cemetery, crem	sition (Name of natory or other place) Ma	Date y 9,	20c. Location	- City or To	wn, State	
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	rate be executed The purial-transit the burial-transit the burial-tra	Examiner	23a. Part1. Exect the disease, or companies, or heart failure. List only of the second should be seen as a condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End: Due to (or Due to (or c.	ı line.	juence or):			rosis			Approximate Interval Between Sanset and D	ween Death
.O. Box 68760,	that the death certificate be ead by the attending physician detached for use as the buri	hysician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	d	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)			1	ate of delive		′ear
ds, P.	se.	by P	Part II. Other significant conditions of Hypertense	m.D	iast	alie	replus	in in Part I.	23e. Did to	obacco use cor res 2 No		ne cause of de ably 4 🗆 U	
Vital Records,	The law ate has b page 2 si	Completed	Animia of a Recent prie	und	•	//	Hype	ries			. Were autop prior to con death? 1 \(\sum \text{Yes}	psy findings a npletion of ca 2 No	available ause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		IED/O	Othe	/	Death (Check only o			-	
on of	ding After fune	-	27. Man of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of li (Month, i		28b. Time of Injury	28c. Injury Work	at	g Home 5 Resid			9	
Division	o afte	Certification:	3 Suicide 6 Could not be determined	288. Place of	Injury - At h	ome, farm, str (y)	eet, factory, office		28f. Location (S City or Tov		ber or Rura	Route Numb	ber,
	Hos Fun Fun	edical (29a. Certifier (Check only one) 1 ✓ Certifying Ph 2 ☐ Madical Exam	/sician: To the be iner: On the basis and manner	of examina	owledge, death	occurred at the tim vestigation, in my op	e, date and pl inion, death o	ace, and due to the courred at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)	
)	To tha within 2 To tha complet	W	29b. Signature and title of certifier ARa heat be	rech	har	las	29c. License		1	29d. Date sign			
1	L		* I HR West Day 30. Name and address of person who of the ROBERT BLK						URG, W	S 2	0847	•	
	Sta Registi		31. Date filed (Month, Day, Year)				H. Spark						
DF	IMH 17 Rev 1/2	001	MA	1 1 600.	140	200	-				1	145	

ORIGINAL

			For State Registrar	State of Maryland	I / Department of Health Certificate of Deat	h	ene g. 2005	15879
ı	Physici	an	1. Decedent's Name (First, Middle, L.	•		2. Date of Death Month		3. Time of Death
	/Medic Examin	al	BEATRICS 4a. Facility Name (If not institution, gr		4b. City, Town, or Locatio	on of Death	8 65 4c. County of Dea	12:41 PM
	LAAIIIII	ĢI	SINAL HOSP	"ITAL	BILTIMO:		NA	
	Funeral Director		5. Social Security Number 6. 214-40-4705 Usual Residence of Decedent	Sex 7. Age (In y.rs. la	st birthday) If Under 1 Year If Under 1 Year Months Days Hours	ler 24 Hrs. 8. Date of Birth Month, Pay,	rear)	thplace (State or Foreign buntry) nn SylVania
	within 72 hours after death with the Maryland ana. than "natural", or items 23a or 28a-f ehow the Medical Evantinar mout be notified at	_	10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	the Ma 28a-f	Funeral Director	Mary and N/	$t \mid B_{i}$	altimore 10f. Zip Code	10	g. Citizen of What Co	1 Yes 2 No
	th with 23s or	ai Di	7041 Tob	v Drive	2/20	9	U<	A
	er deal	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of Hispanic of Hispanic Office Yes, specify Cuban, Mexico	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
50	ai', or	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Speci	ify:	Specify: P	lack
9200-612	d within 72 hours after death with the Marylan plans plans, natural; or items 23a or 28a-1 show the Medical Examinatina must be notified at	Completed	15. Decedent's fine (Specify only highest g		16a. Decedent's Usual Occupation (Give kind of work done during m life, DO NOT use retired)	lost of working	6b. Kind of Business	/Industry
717	77 '- be	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Educator	F	Balto City	Public Schs
and	be flled Ital Hygi od other evant, I	Be	17. Father's Name (First, Middle, Las	(t)		ther's Name (First, Middle, Ma	aiden Sumame)	1 1 1
		ဥ	19a. Inform nt's Name/Relationship	CINES	19b. Mailing Address (Street and Nun	1 Zabeth	City or Town, State,)right Zip Code)
, Mary	s 1 and 2 should Health and Mar Item 27 is marks other traumatic		Mrs. Deborah	Holley Tucker	7067 Toby .	Drive Ba	Ho.Md.	21209
altımore,	90 = 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐ Removal from State	nce of Disposition (Name of metery, crematory or other place)	Fluid	Oc. Location - City or	ST ASSET TO A REPORT WE
	그 돈 돈 글 .		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Aico		rison Forest	-114 -	wings N	
ñ	Depa impo any ic		boseph	L. Buss	Joseph L. Ru	iss tuneral	Home, P.	A. 1216
I				nplications that caused the death, y one cause on each line.	Do not enter the mode of dying, such	as cardiac or respiratory arres	șt,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASVS TO	LE			
Ė	Examiner		Sequentially list conditions.	b. HELRT	DISEASE			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):			1
oʻ	an and	Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			
98/80	eath certificata be axecuted attending physician and for use as the burial-transit	dicai	•	d				
ox e	n certifi anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan			23d. Date of de	livery
o. B	The law requires that the death certificata be axecuted to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal of dead of time of dead of the second of the s			Month	Day Year
О	res that the de signed by the a be detached f	by Phy		contributing to death but not resul	ting in the underlying cause given in Pa	rt I. 23e. Did toba	acco use contribute to	o the cause of death?
Spuc	w requires been sign should be	ted b		's Dement		1 ☐ Yes	s 2 (2No 3 □ P	robabiy 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed	Cerebraa	sullar dis	ease	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Ta Ta		e Co	25. Was case referred to medical	T	26 Pl		(StNo 1 ☐ Yes	2 □ No
5	Physician: r this certific ral diractor,	ToB	examiner? 1 ☐ Yes 2 ☑No		R/Outpatient 3 DOA Other: 4 D	Nursing Home 5 Residen		ecify)
	ding Afte fune	tion;	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigati	(Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 □ Yes 2	28d. Describe hov	v injury occurred	
Division	Attending er death. ractor: After by the fune	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 390 Place of Injury - At hon	ne, farm, street, factory, office		eet and Number or R State)	ural Route Number,
ō	교육등교	Cer					·	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying F (Check only 2 Medical Exc	eminer: On the best of my know eminer: On the basis of examination and manner stated.	rledge, death occurred at the time, date on and/or investigation, in my opinion, o	and place, and due to the cat death occurred at the time, dat	use(s) and manner as te and place, and dur	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		d. Date signed (Moni	
	1/1		30. Name and address of person wh	o completed cause of death (Ita-	23a) (Type Righ)		5-9-05	
- F	51		Holy R Dahlin	o completed cause of death (Item	23a) (Typo, Print) 38 Greene Tree St	e 300 ; Balt	imore, 72	D 21208
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's signatu	ure & Shoule			

S

HOLEY, BOARICE

PT KNOWIN AS

			State of Maryl		rtment of Health and	Mental H	ygiene) 115	15000
			1. Decedent's Name (First, Middle, Last)	Certi	ificate of Death	2. Date of D	Reg. No.	10000
	Physicia		Richard Hill			May 7	Day Year	3. Time of Death 12:03 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	12.03 F
			524 North Charles Street Apt	. 515	Baltimore		NIA	
	Funeral			yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mir		irth (S. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	S Yrs.		Junel	7,1939 Mai	ryland
	yland 10w			. City, Town or Loca	ation			10d. Inside City Limits
	e Mar ia-fsh lifted	ctor	Maryland N/A	Baltir	more			1 TYes 2 No
	or 28	Dire	10e. Street and Number	ot.	10f. Zip Code		10g. Citizen of What Cou	ntry?
	s 23e	eral	5J4 IV, Charles St. 4 11. Marital Status 12. Was Decedent Ever	515	21202		USI	4
10	tter de r Item iner (Fune	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in Amed Forces? 1 □ Yes 2 ▼ No		as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	lo- 14. Race - Ameri Black, White,	etc.
036	ral', o	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	10	☐ Yes 2X No Specify:		Specify: B	ack
21215-0036	within 72 hours atter death with the Maryland ene. than "netural", or Items 23e or 28a-f show the Mudical Examiner must be notilised at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give kii	int's Usual Occupation ind of work done during most of w	orking	16b. Kind of Business/in	dustry
121	within ene. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	D. +	O NOT use retired)	0.4-	R&G 1/2	d'no
	filed Hygie othar ent, II	Be Co	17. Father's Name (First, Middle, Last)	Houl	- Jule Sin		le, Maiden Sumame)	naing
Maryland	ould be Mental Marked c	To B	Alfred Hill Sr.		Dor	othy	Chapm	lan
lan	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print) (nepher	N) 19b. Mailing	Address (Street and Number or I	Rural Route Num	ber, City or Town, State, Zij	Code)
	1 and 1ealth 1m 27 ther tr		20a. Method of Disposition 20	Db. Place of Disposit	I McKean A	ve Bo	alto. Nd.	2/2/7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "netural", or Items 23e or 28e-1 show appring to other traumatte event, Ite Mudical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State	cemetery, crema	atory or other place) 5/1	4/2005	20c. Location - City or To	own, State
Ë	artme ortani injury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Aicensee	rinity	Cemetery Name and Address Pacility	1/2005	Dundalt	s, Ivia.
B	permit. Departr Importu any inji		Joseph L. Ru	N 22	seph Li Russ	Fune	ral Hame, P.	Α.
	4		23a. Part/. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.	death. Do not enter	the mode of dying, such as cardi	ac or respiratory	arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	une t	theochete	Cardin V	made Drisk	Onset and Death
	/Medical Examiner		resulting in death) Due to or as a con	sequence of):				
		er	Sequentially list conditions, b. Pure to (ur as a con	tsequence of):				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
ó,	e exec ian an urial-tr	Exa	resulting in death) Last Due to (or as a con	isequence of):				
8760,	icate be executed physician and s the burial-transit	dical	d	-				
9	± on a		IF FEMALE: 23c. If yes, outcome of pro	egnancy			and Date of deliver	
Вох	that the death certitied by the attending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time	Fetal death 3 □E	Ectopic pregnancy Other (specify)		23d. Date of deliver	Day Year
P.0	at the d by the tached	hys	9 ☐ Unknown					
	as and a		Part II. Other significant conditions contributing to death but not	resulting in the und	derlying cause given in Part I.		tobacco use contribute to t	,
ord	w requir been si should I	eted				1	Yes 2 No 3 Prot	pably 4 OUnknown
Records,	0 2 0	Completed				24a. Wa aut		psy findings available mpletion of cause of
a	ician: The certificate ha rector, page		25. Was case referred to medical			1 Tr Yes	2 □ No 1 DeYes	2 No
· Vital	Physician: r this certific ral director,	To Be	examiner?	2 EP/Outpatient		eath (Check only	rone) sidence 6 ⊠Other (Specif	Scono
ηof	ding Physician: Ater this certific funeral director,		27. Manner of Death 28a. Date of Injury		28c. Injury at Work?	28d. Describe	how injury occurred	y) scene
Sior	Attanding ir death. ector: Atter by the fune	catic	2 Accident investigation	-7 Injury	M 1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - 4 ☐ Homicide 28e. Place of Injury - 4 building, etc. (Sp	At home, farm, stree pecify)	et, factory, office	28f. Location City or To	(Street and Number or Rura own, State)	Il Route Number,
_	Hospitel 24 hours a Funaral I		29a. Certifier 1 Certifying Physicien: To the best of my	knowledge, death (occurred at the time, date and plan	ce, and due to the	o cause(s) and manner as s	tated
	To the Hospitel or Attendi within 24 hours after death. To the Funaral Director: / completely tilled in by the fi	Medical	(Check only one) Medicel Examiner: On the basis of examiner and manner stated.	nination and/or inve	estigation, in my opinion, death oc	curred at the time	a, date and place, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. License number OCME		29d. Date signed (Month,	Day, Year)
			Theodull. King	wy			May 8, 2005	
L	11		30. Name and address of person who completed cause of death. THE ODORE M. King	(Item 23a) (Type, Pr	^{rint)} 111 Penn Street	Baltir	more, Marvlan	d 21201
	Sta	te						
42	Registr	ar	MAY 1 1 2005 May	signature	Speciel			

Richard Inglis 05-03128 RPD

	ian	1. Decedent's Name (First, Middle, I	F. TNO/	15			2. Date of D	Day	Year	3. Time of De
/Medi Exami		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	or Location of De	May 5	7	ounty of Death	<u> 0923 I</u>
		3711 Gough Stree			Baltimor					
Funeral Director		5. Social Security Number 6. 043 - 42 - 5603	. Sex 7. Age (In yrs. 1)	i. last birthday) 7 Yrs.	Months Days			ay, Year)	9. Birth Cou	pplace (State or F untry) HINGTO
		Usual Residence of Decedent	100.0	-			13/12	-1 1760	10/12	
Shoy	5	10a. State 10b. County	10e. C	Sity, Town or Lo	7 , /					10d. Inside City
or 28a-f show	Funeral Director	10e. Street and Number		/-	10f. Zip Code	MORE		10g. Citizer	n of What Cou	untry?
23a o	raiD	3711 Gough	Street		21	1224			U.S.	A.
or items 23a	nne	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in t Armed Forces? 1 X Yes 2 □ No	U.S. 13.	Was Decedent of H If Yes, specify Cubi	Hispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	Race - Amer Black, White	
E O	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 198	/	1 ☐ Yes 2 No	Specify:		Sp	pecify: IN	bite
"natural", edical Exa	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	edent's Usual Occup thind of work done DO NOT use retired	pation during most of w	rorking	16b. Kind	of Business/I	ndustry
than tran	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		t15+			ART	+
t of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Mudical Examinar must be notified at	To Be Completed	17. Father's Name (First, Middle, La	and the second s	, ,		18. Mother's N	ame (First, Middi		~	
Menta rked atic e	To	Edwin	W. I.	Nglis			ZABEY			MBERG
th and 7 is m traum		Beatrice Do	CType, Print) 2 Sey - Sister	19b. Maili	ing Address (Street	and Number or	^	1 1	12	/ /
of Health I Item 27 I		20a. Method of Disposition	20b.		osition (Name of		Date	20c. Locat		own, State
는 다 는		1 ☐ Burial 2 Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control Con	Hemoval from State	CEN Mi	matory or other place	eten Mr	+V 7, 2005	BAI	HIMOR	Re MAR
Department o important: if any injury or once.		21. Signature of Funeral Service Lic		2	2. Name and Addre	ess of Facility	los JA	. Fun	enal t	tone 1
		23a. Part 1. Enter the disease, or co	1. Januar		165 5.	CONKIN	4 57-	DAIT	to Ich	Approximate
ysician Medical caminer	-	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Atheroscler Due to (or as a consect.) Due to (or as a pone)	otic Conquence of):						Interval Betwee
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Jackson, Rayfield B. Maryland 21215-0036

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			for State Registrar	State of Mi	ai yiai io		tificate of		-	Reg. No.	36	15000
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De	ath		3. Time of Death
	Physici /Medio		Rayfield Pr	eston Jac	kson				Month	Day	200 F	1350M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of E	Death	4c. Coun	ty of Death	
Е			Dorchester G				CAMBRI				RCHES	
	Funeral			Sex 7. Ag 1	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da			lace (State or Foreign try)
	Director		Usual Residence of Decedent	'	78				June 2	4,1926	Mary	land
-	ylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation				1	Od. Inside City Limits
:	Ba-f	cţo	Maryland Dorch	ester	Hur1	ock						1 Z Yes 2 ☐ No
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	death with the Maryland ms 23a or 28a-f ehow	ra	6215 Mission		- · · · ·		2164			USA		
_	ter de Inerr	Funeral	 Marital Status Married 2 Married 	12. Was Decedent Armed Forces? 1 Yes 2 1		. 13. V	Yas Decedent of F f Yes, specify Cub	fispanic Origin an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.))- 14. Ha	ace - Americ ack, White,	
250	72 hours after natural', or Ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1	I□Yes 20 No	Specify:		Spec		o.l.
5	2 ho	ted	15. Decedent's			16a. Deced	lent's Usual Occup	ation	f die e	16b. Kind of	BLa Business/Inc	
	ithin 1990.	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	kind of work done OO NOT use retire	d) most of	r working			
7	s filed within I Hygiene. other than "		unk.			Se	curity G				try P	ride
	i be fi	Be	17. Father's Name (First, Middle, La						Name (First, Middle	_	ате)	
2	nit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. artiment of Health and Mental Hygiene. Injury or other traumatic event, the Marulcal Examinat must be mailled at 16.	은	Lewis Phillips 19a. Informant's Name/Relationship			19h Mailin	n Address (Street		ssie Jac or <i>Rural R</i> oute Numb	kson	n State 7in	Code
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ย์	of Heal		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of natory or other pla		Date	20c. Location		
aithmor	Page nent c		1 Narial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec				Cemeter	· 1	5-07-2005	Hurloc	k.Mar	vland
	permit. Pages 1 an Department of Healt Important: If Itam 2 any Injury or othar once.		21. Signatur of Funeral Service Lic	ensee/) /			. Name and Addre	ss of Facility	uneral Ho			
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	the death. ne.	Do not ente		,				Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)			scle:	rohe l	east	disease	e		
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9 K	w requires that the death certificate to been signed by the attending physis should be detached for use as the t	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of oregonan	CV						
מַ	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal c	death 3□	Ectopic pregnancy Other (specify)	/			ate of delive fonth	ry Day Year
)	t the c by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9⊡ Unknown								
r n	ss tha gned I	by P	Part II. Other significent conditions	contributing to death b	ut not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?
ָרָבְילָ ברים	equire sen si ould b								1	Yes 2□No	3 Prob	ably 4 Donknown
ັນ .	law r las be	ompleted							24a. Was		. Were autor	osy findings available inpletion of cause of
	cate h	Con							perfo 1 ☐ Yes	2 No	death?	2 No
VII	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			3 DOA Ott		Death (Check only			
5 8	rhys ral di	To It	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		R/Outpatien 28b. Time of	1 JU DOA	4 🗀 140131	ng Home 5 Resi			')
5	naing ith. :: Afte e fune	atior	1 Matural 5 Pending 2 Accident investigati	(Month, Da	Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No				
2	Atta ar dea acto by th	ertification:	3 Suicide 6 Could not 4 Homicide determine		ury - At hom	ne, farm, stre	eet, factory, office		28f. Location (City or To		nber or Rura	l Route Number,
5	rs after or rs after all bir led in	Ceri		banding, et	o. (Opacity)				City of To	wn, State)		
	Hosp 4 hou Funer fely fill	edical	(Uneck only 2 Madical Exe	Physician: To the best eminer: On the basis of	examination	ledge, death on and/or inv	occurred at the timestigation, in my o	ne, date and p	place, and due to the	cause(s) and n date and place	nanner as st	ated. the cause(s)
-	to the hospital or Attanding Physician: The law fequires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens			29d. Date sign		
	- 3 - 8			My W					59			
2	KX		30. Name and address of person when NI44 mm AT	o completed cause of d	eath (Item 2	23a) (Type, I	Print)		,	2/		
_ \	<u> </u>		NIHAMMAT	AF2AC	3	00 H	risora.	57, 6	AMBRID	45	MO	21601
	⊮ Sta	ite	31. Date filed (Month, Day, Year)	2. Registra								

		1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
Physicia /Medic		Herman C. Jackson, Jr.		April	16,2005 Year	4:55 PM
Examin			. City, Town, or Location of Death		4c. County of Death	
		Prince George's Community Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Cheverly Under 1 Year If Under 24 Hrs.	8 Date of Birth	Prince Geo	orge s
uneral irector			onths Days Hours Min.	8. Date of Birth (Month, Day) Jan.3,	1951 Wash	ington, D.C.
>		Usual Residence of Decedent				
shov ed at	ū	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1127 Yes 2 ☐ No
28e-I	Director	MD Prince George's Capitol Hei	Of, Zip Code	1	0g. Citizen of What Co	
23e or		1727 Kenilworth Avenue	20743		US	
hygiene. d other than "natural", or liems 23e or 28e-f show event, the Medical Examinat must be notified at	Funeral	Amed Forces? If Ye	Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
', or li	by Fu	1 ANever Married 2 Married 1 ☐ Yes XXNo	Yes 2⊠ No Specify:	,	Specify: B1	
atura cal E	ted t	15. Decedent's Education 16a. Decedent'	s Usual Occupation	7.7	16b. Kind of Business/	Industry
Medi "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO I	of work done during most of work NOT use retired)	ing		
riygiene. other than ent, the N			r - Bricklayer		Private	
	Be	17. Father's Name (First, Middle, Last) Herman C. Jackson, Sr.	18. Mother's Name Ernestin		Maiden Sumame) us Jackson	
and Menta is marked aumatic e	은	•				(in Code)
i health and Mer Item 27 is marke other traumatic		Karen R. Jackson - Sister 1727 Ken	ddress <i>(Street and Number or Rura</i> ilworth Ave., Ca	pitol H	eights, MD	20743
f Item		20a. Method of Disposition XX Buria 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetary, cremator	ry or other place)		20c. Location - City or	
tant:		`4 □ Dynayon 5 □ Other (Specify) MT Zion Ceme			altimore, M	
Important: If Ite any injury or otl one		21. Signature of Funeral Service Licenseed 22. Na BO31	me and Address of Facility Lat Georgia Ave., NW	ney's F	uneral Home	on Inc.
		 Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or mart failure. List only one cause on each line. 	e mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
ysician Iedical		resulted in death)	cel			Oriset and Deam
aminer		Due to (or as a consequence of):				
*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
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physician and the burial-transil	dical Ex	resulting in death) Last Due to (or as a consequence of):				
ng ph) as th	(a) +	IF FEMALE:				
attending properties as	lan/M	23b. Was decedent pregnant in the past 12 months?	opic pregnancy		23d. Date of deli	very Day Year
by the stached	Physici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	ner (specify)			
igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
(7) TH				1 □ Ye	es 2⊡No 3⊡Pro	obably 4 Unknown
as been 2 shoule	Completed			24a. Was a	v prior to c	topsy findings available completion of cause of
cate has	Соп			perform	ned? death?	2 No
certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
this al di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of			ence 6 Other (Spec	cify)
arn. r: After e tuner	atior	1 Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		, ,	
affer death. Director: A in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (SI City or Town	treet and Number or Ru n. State)	ral Route Number,
re arr rel Di lled in						
within 24 hours affer d To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occ one) Medical Examiner: On the basis of examination and/or investigated.	curred at the time, date and place, gation, in my opinion, death occurr	and due to the cred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the comp	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month	* '
		OWINDER Guesse	20053200		4-16-	05
	1					
		30. Name and address of person who completed cause of death (Item 23a) (Type. Prin Wendall Pierson, MD 3001 Hospital Dr	-	ממטט חש		

				1 - For State Registrar	State o	f Maryland		artmen rtificat			Mental H	ygiene Reg. No	GUU.	15884
		Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of D Month	Death Day	y Year	3. Time of Death
		/Media	cal	Barbara J. Kem 4a. Facility Name (If not institution,				41 011	7		05	05	2005	22:38 PM
		Examir	ner	Upper Chesapea			r		Air	ocation of Death	1		. County of Death Harford	1
		Funeral			. Sex	7. Age (In yrs. la				If Under 24 Hrs. Hours Min.	8. Date of B	Sirth Day, Year)		nplace (State or Foreign untry)
		Director		214-58-9098 Usual Residence of Decedent	1□M 2 X F	52	Yrs.		Days	Hours Will.	11/16/	1952		ryland
		ehov	5	10a. State 10b. County		10c. City,	, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 🖫 No
		ith the Marylar or 28a-f ehow or notified at	Director	MD Balti 10e. Street and Number	more	Wh	nite M	arsh 10f. Zip	Code			10a Cit	tizen of What Cou	
		ours after death with the Maryland ral', or Items 23e or 28e-f ehow Examilier invest by notified at	rai Di	11616 Jerome A	venue				1162				.S.A.	
		ltems Pur h	Funerai	11. Marital Status	Armed Fo	edent Ever in U.S proes?	5. 13.	Was Deced If Yes, spec	dent of His offy Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No Rican, etc.)	10-	14. Race - Amer Black, White	
do	36	within 72 hours after ane. then "natural", or Ite	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Giv Year or D	ve		1 🗆 Yes	2 ∑ No	Specify:			Specify:	+ 0
223	21215-0036	"natural", or	sted	15. Decedent's (Specify only highest			16a. Dece	dent's Usua	al Occupat	ion uring most of wor	tina	16b. K	Whi (ind of Business/I	
3	2	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired)	ing most of wor	King			
	, 12	filed v Hygie ther t	Co	12 17. Father's Name (First, Middle, La	ıst)			ok	1	18. Mother's Nam	ne (First Middl		estaurar Sumamal	ıt
	au	ld be ental ked o	To Be	(Unknown)Braun	,						Johnson		ourname)	
,	ary	12 should be filed within h and Mental Hygiene. 7 Is marked other then "traumatic event, the Max	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street ar				or Town, State, Z	ip Code)
5/5/05	altimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any njury or other traumatic evone.		Craig H. Kemmer	zell (hu					Avenue				land 21162
2	ore	it of H it of H or oth	l y	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		State Ce	ace of Dispo metery, crei	matory or o	ther place,		Date		ocation - City or 1	
2	Ħ	it. Pa		 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie 		Met	ro Cre	emato:	cy, I	nc. 05/0	09/2005	Balt	imore,	Maryland
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				23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that only one cause on e	caused the death.	. Do not ent	ler the mod	e of dying,	such as cardiad	or respiratory	arrest,	PHALYIC	Approximate Interval Between
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		/Medical Examiner		resulting in death)		(or as a consequence 40 6 60 f		= mil	L					4 years
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2	Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place of Dea	1 ☐ Yes ath (Check only		1 Yes	2□ No
2	of V	Physicien: this certific al director,	ည	1 ☐ Yes 2 ② No			ER/Outpatier)A Other	4 Nursing H	lome 5 ☐ Re	sidence	6 □Other (Spec	ify)
6		fter inei	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o Injury		8c. Injury a Work?	at	28d. Describe			
mme	Division	Attending r death. Sctor: After by the funer	ertification:	2 Accident investiga 3 Suicide 6 Could no	t be 28e, Place	of Injury - At hor	me, farm, str	M reet, factory		es 2 □No	28f. Location	(Street an	nd Number or Ru	ral Route Number,
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Ke		To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E		asis of examinati iner stated.	vledge, deat ion and/or in	h occurred vestigation	at the time , in my opi	, date and place nion, death occu	, and due to the	e cause(s) e, date and) and manner as d place, and due	stated. to the cause(s)
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	3.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 1 2	2005	legistrar's Signati	ure							

DHMH 17 Rev 1/2001

2238

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Ellen Catherine Kahler May 10, 2005 7:33 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Renaissance Gardens FUNDER 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 17, 1 Parkville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 89 212-07-0195 Yrs. Director 1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County ehow 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23e or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. Funeral 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic access. Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Angland Cecilia 0'Shea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kahler (husband) Charles Р. 8810 Walther Blvd., Parkville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cem. 5/14/2005 21. Signature of Function Service 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bacterial preomonia /Medical Due to (or as a consequence of): Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria To the Hospitel or Attending Physicien: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 \sum Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 No Division of Vital 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification; To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 24 hours after death. Funerel Director: ₽ investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 m 175864 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna-Monins 9800 ua Ither State 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 1 2005 Registrar

			For State Registrar	State of I	Maryland / De	epartment Certificate				iene	05	15000
4	Physicia	an	Decedent's Name (First, Middle,		ll Francis	Kifer	, Sr.	2	. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, To	own, or Loca	tion of Death	May 6,	4c. County	of Death	12:45 P
	LAdimi		1734 Bayard Ave	enue		Dı	ında1k			Balt	imor	е
	Funeral Director				Age (In yrs. last birtho 86 Yr	Months	Year If U	urs Min.	Date of Birth (Month, Day Oct. 18	Year)	Coun	lace (State or Foreign stry) yland
_	ט		Usual Residence of Decedent							72323		
	a-f show	ctor	10a. State 10b. County Maryland I	Baltimore	10c. City, Town o	or Location		Dunda1	k		10	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	or 28	Dire	10e. Street and Number			10f. Zip C			1	0g. Citizen of V		
	eath v	erai	1743 Bayard Ave	enue	ant Ever in II S	13 Was Decedo	2122		fy Ves or No-	United	e - America	
36	d within 72 hours after death with the Maryland Jiene r than "natural", or liems 23a or 28a-f show The Musical Establish at Inval be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ※ Widowed 4 ☐ Divorced	Armed Force	⊠ No	13. Was Decede If Yes, specif			can, etc.)		k, White, e	
9-0	2 hou		15. Decedent's	Education	16a. D	ecedent's Usual	Occupation			16b. Kind of Bu		
Maryland 21215-0036	within 7. ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	Give kind of work ife. DO NOT use		most of working		G1	1 3	
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lary	2 should be and Mental is marked isumatic ev		19a. Informant's Name/Relationshi			Mailing Address (-		
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nor	Pages nent of B int: if ite iry or of		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate cemetery,	crematory or oth	er place)	1			•	er, MD
Baltimore,	permit. Pages Department of Important: if i any injury or one		21. Signature of Funeral Service Li		-	22. Name and Duda – Ru	Address of F Ck Fun	acility eral Ho	me of 1	Dundalk	, Inc	:•
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	Pnysician		shock, or heart failure. Live o Immediate Cause (Final disease or condition	nly one cause on eac	h line.	12000	,					Interval Between Onset and Death
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928	icate b physic the b	dica	•	d								
O. Box 6	that the death certificate be executed to the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal death It at time of death	3 ☐Ectopic pred				23d. Dat	e of delive	ory Day Year
٩,	res that the signed by th I be detache	by Ph	Part II. Other significant condition	s contributing to deal	th but not resulting in t	he underlying cau	ise given in l	Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
ords	faw requires as been sign 2 should be								1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
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of/	Physician: this certific ral director,	- T	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inc	patient 2 ER/Outp		Other: 4	Nursing Home		ence 6 Oth)
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Division	F Sir G	Certification:	3 Suicide 6 Could no determin	28e. Place of	f Injury - At home, farm , etc. <i>(Specify)</i>	n, street, factory,	office	28	f. Location (Si City or Town	treet and Numb n, State)	er or Rurai	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physicien: To the b xeminer: On the bas and manne	est of my knowledge, is of examination and/	death occurred at or investigation, i	the time, da	te and place, an , death occurred	d due to the c at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	SEBA	STIAN JE		License num	551 F	1 2	9d. Date signed	1	Day, Year)
7	9		30. Name and address of person w	no completed cause	of death (Item 23a) (T	ype, Print)		2017	\\\	-)/-	705	7/77//
	Sta		3023 EAS 31. Date filed (Month, Day, Year)	TERW 32. Reg	pistrar's Signature	=	ンけして	Marc	- 40/0	ery 10	WY	21224
	Registi	ar	MAY	1 1 2005	Home !	4. Som	1/2					

DHMH 17 Rev 1/2001

ORIGINAL

David Kearns Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-3119 State of Maryland / Department of Health and Mental Hygiene 1-65 tas 1-05 t AKG 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** KERNS DAVID 2005 May /Medical 1:10 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4200 block of Lombard Street Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 13-94-493 1**⊘**M 2□F 40 Yrs. Director Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show BAltimore 1XYes 2 □No Completed by Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Klowa 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTuse retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED DISABLED 841 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be tilt ment of Health and Mental Hy lant: If item 27 Is marked oth jury or othar traumatic evant 18. Mother's Name (First, Middle, Maiden Surname) Be Ohr ACKSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Department of Important: If any injury or once. meters MAV * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Service Licensee 22. Name and Address of Pacility oh N 0 5... CONKling 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cocaine Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons nuence of): Examiner slcian and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the the as IF FEMALE use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2□ No 2□No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 QOther (Specify) at 2 1 XYes 2 No scene 28a. Date of Injury Found, Day Year) 5-5-05 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification; 28d. Describe how injury occurred unk 1 Natural Found, 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4200 Blk. Lombard St 4 🗌 Homicide Found in Field Baltimore, To the Hospital of within 24 hours of To, the Funaral D Md 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

OCME

May 6, 2005

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 15, 2005 Karen Ann Leschke 1:15 p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1808 Creston Drive Forest Hill Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 2, 1961 5. Social Security Number Birthplece (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2√2 F 44 061-54-3028 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "natural", or iteme 23e or 28e-f eho other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Md. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 U.S.A. 1808 Creston Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 █ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins School Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Director of Faculty Records of Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in ment of Health and Mental I Nancy Kiederer Americo J. Longo ဝ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernst Leschke/husband 1808 Creston Drive, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/2005 injury ` 4 ☐Donation 5 ☐ Other (Specify) Highview Mem. Gdns. Fallston, Md. permit. 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Buin a. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Varian disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events tha attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Tof 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 Natural death. 1 Yes 2 🗆 No s after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 0 within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ZU Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) my D41490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21236 Franklin Sq. DK 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

			1 - For State of Mary		artment of Heartificate of De			ene No2005	15880
			Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Gary Dale		Lyons	n	194 0	75, 2005	9-2SP M
	Examin	ier	4a. Facility Name (If not institution, give street and number)	(attal	4b. City, Town, or Lo	ocation of Death		4c. County of Dea	th Amedal
			5. Social Security Number 6. Sex 7. Age (In	yrs last birthday)	If Under 1 Year If	f Under 24 Hrs. 8.	Date of Birth	* / * / * /	tholace (State or Foreign
	Funeral Director		213-64-0482 ¹ ፟፟XM 2□F	52 Yrs.		Hours Min.	(Month, Day, Yo		thplace (State or Foreign buntry) St Virginia
	P.		Usual Residence of Decedent				.g. 2091	. 752 WC.	
	shoy	5		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XXNo
	28a-f	ect	MD Anne Arunde1	Glen Bu	ırnie 10f. Zip Code		100	. Citizen of What Co	
	3a or	Funeral Director	328 Highland Drive, Apt. 103	3	2106	51	109	USA	John y .
	death ms 2	nera	11. Marital Status 12. Was Decedent Ever Amed Forces?		Was Decedent of Hispa If Yes, specify Cuban, I		y Yes or No-	14. Race - Ame	
9	or Ite	II.	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No			mexican, rueno nic Specify:	an, etc.)	Black, Whit	e, etc. White
21215-0036	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show disal Examinat must be rodified at	d by	3 Widowed 4 Divorced Year or Dates:				100		
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212	d within giene. or than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Ware	ehouseman			Terminal	Corp.
P	ould be filed with Mental Hygiene. arked other than atic event, It e M	Bec	17. Father's Name (First, Middle, Last)		18	3. Mother's Name (F			
yla	should but marked	ဂ္	Robert J. Lyons, Jr.		Tall Andrews	Alice I	eusenbe	rry	
Maryland	01 00 00 00		19a. Informant's Name/Relationship (Type, Print) Alice Lyons (Mother)		ng Address (Street and				
	of Health Item 27			Ob. Place of Dispo	3 Clark Sta	Date		c. Location - City or	
JOI.	ages ant of nt: If It		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	cemetery,crei Metro Cre	matory or other place)	5-11-2		altimore,	
altimore,	permit. Pages I Department of H Importent: If Ite eny Injury or ot once.		21. Signature of Euneral Service Licensee		2. Name and Address of	of Facility			, IID
m	Depa Impo eny I		Salat A West		Hardesty F 12 Ridgely	Avenue,	me, P.A Annapol	is, MD 21	401
46			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying, s	such as cardiac or re	spiratory arrest	•	Approximate Interval Between
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	/Medical Examiner		Due to (or as a cor	nsequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):				-	-
	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events						
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8760,	hy:	Physician/Medical	d						
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Bo	atten atten	cian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of dei Month	Day Year
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s, P	es that igned b	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause given i	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
-2	w require been sign						1 🗌 Yes	2 No 3 □ Pr	obably 4 Unknown
Vital Reco	as be	Completed					24a. Was an autopsy	prior to	stopsy findings available completion of cause of
al R	icien: The t certificate a rector, page	So					performe 1 Yes 25		21 No
\ <u>;</u>		o Be	25. Was case referred to medical examiner? Hospital:		Other	6. Place of Death (C			
0	Phys or this aral di	F	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time o	II JU DOA	4 ☐ Nursing Home 28d	5 🔲 Residence I. Describe how		cify)
ion	Attending I r death. ector: After by the funer	atio	1	ar) Injury		s 2 🗆 No			
Division	or Attendente of the or Attendente of Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)		reet, factory, office	28f.	Location (Stree	et and Number or Ru State)	ural Route Number,
	itel or A								
	To the Hospitel within 24 hours e To the Funerel I completely filled	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	y knowledge, deat imination and/or in	h occurred at the time, exestigation, in my opinion	date and place, and ion, death occurred	due to the caus at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the Hi within 24 To the Fu	Me	29b. Signature and title of certifier		29c. License nu	umber	29d.	Date signed (Mont	h. Day, Year)
)	So	2) 12 n	n1)	1)48	006	0	5/09/2	005
1	1		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	11	e i.	P	. \ \
			31. Date filed (Month, Day, Year) 32/Registrar's S	SVI	HVY.	Dr.	4/20	Bunn	(الرم ١١٠١١)
	Sta Registi	10.00	31. Date filed (Month, Pay, Year) 32/Aegistrar's S		auto	,			
			1-000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item #8&9&11 PER FH G@estifiqate/05 Depath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Robert E. Lee, Sr. 12:12 p , M May 5, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City 4514 Taraley Court Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUNE 07, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 □ F Months Yrs. Director WASHINGTON, D.C. 579-26-3764 Usual Residence of Decedent Washington, DC Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-1 show traumatic evant, It e Widical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Ellicott Clty the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural" ~." any niury or other traumatic average. with ö Itams 23a 21042 U.S.A. 4514 Taraley Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ☐ No 3√Widowed 4 □ Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Mail 12 Postal Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Julian R. Lee Bessie K. Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter

20b. Place of Disposition (Name of cemetery, crematory or other place) 4514 Taraley Ct. Ellicott City, Maryland 21042 Date 20c. Location - City or Town, State Ms. Sandra Hawkins 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 05/11/2005 Union Cemetory Leasburg, Virginia 21. Signature of Funeral Service Licensee Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

3871 Old Columbia Pike Ellicott City, MD 21043

3871 Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

3871 Slack Funeral Home, P.A.

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3871 Old Columbia Pike Ellicott City, MD 21043

3871 Old Columbia Pike Ellicott City, MD 21043

3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition Priysician /Medical resulting in death) Due to (or and consequence of) **Examiner** 1851 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner s a consequence of): Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 Yes 2√No Other. 4 Nursing Home 5 Schesidence 6 Other (Specify) tiflcation: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760,

er death. the f ractor:

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n 24 hours n 24 hours na Funara sletely fille edical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	icien: To the best of my knowledge, death occi er: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and duration, in my opinion, death occurred at the	e to the cause(s) and manner as stated. le time, date and place, and due to the cause(s)
withii To the Comp	29b. Signatore and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
	pare con	han, mi)	D35217	May 5, 200
20	30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, Print) Le Patrxut Pk	wy Sute 210, (Colombia mi) 2/09
State Registrar	31. Date filed (Month, Day, Year) MAY 1 1 200	a. Registrar's Signature		

28e. Place of Injury - At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be

3 Suicide

4 | Homicide

			_ For	icase i	* -		nd / Dep	artme	ent of H	lealth and	d Mental Hy		_	Die.		
_			1 - State Contificate of Dooth									Reg. N	Reg. No. 2005 5991			
	Physici /Medi		Diognor Ann Moticina							2. Date of D Month May				3. Time of Death		
	Examir		4a. Facility Name (If not inst		4b. Ci	ty, Town, o	r Location of De	eath		4c. County of Death						
			Hillside House Clarksville								I	Howard				
	Funeral Director		5. Social Security Number 207-03-4801	6. Se	Sex 7. Age (In yrs. last birthday) 1 M 2 X F 87 Yrs.			Months Days Hours Min (Month				Day, Year) (Cou	ntry)	
	work wow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													
	Ba-1-e	Director	MD How	ard		Lá	aurel								1 ☐ Yes 2 X No	
36	다 다 0, 28	Oire	10e. Street and Number					10f.	Zip Code			10g. C	itizen of V	Vhat Cou	ntry?	
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	72 hours after death with the Maryland "natural", or items 23a or 28a-1 ehow idical Examination by notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☒ Div.	Armed Forces? 1 ☐ Yes 2 X No			If Yes, s	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					Black, White, etc.			
ö	tura	ed	15. Dec	edent's Edu	ıcation		16a, Dece	dent's U	sual Occup	ation		16b.				
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an	Q to D	ToB	Stanley Mat	kins					i	Veroni	ca Ignat	avio	ch			
Maryland 21215-0036	shound N	_	19a. Informant's Name/Rela	tionship (T)						and Number or	Rural Route Number, City or Town, State, Zip Code)					
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B	permit. Departr Importé any inju		Valet 1:44		1//	MOO	1773	Dona	ldson	Funera	l Home,	P.A.		a 20	707-1389	
	_		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00773 313 Talbott Ave. Laurel, Maryland 20707-4 Approximation of the mode of dying, such as cardiac or respiratory arrest, Interval E											Approximate		
100			shock, or heart fallure. List only one cause on each line. Immediate Cause (Final											Interval Between Onset and Death		
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Division	of or Attending after death. I Director: After d in by the fune	Certification:	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)										er or Rur	al Route Number,		
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	Physici		1. Decedent's Name (First, Middle, Last, ELLEASE		LEOD			2. Date of Death Month	Day Year	Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	40	4b. City, Town, o	r Location of Death		4c. County of Death			
			NORTHWES				llstown		Baltimore			
	Funeral Director		5. Social Security Number 215-01-9728 7. Age (In yrs. last birthday) 1 M AF 91 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. 12 09 Usual Residence of Decedent							(State or Foreign		
	yland		10a. State 10b. County		10c. City, Town or Location				10d. Ir	nside City Limits		
	Ba-f si	Funeral Director	MD NA		Baltimo	re				Yes 2 No		
	with the a or 2	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Country?			
	death me 23	era	3700 Greensprin	g Ave 12. Was Decedent Ever in U.S. 13.			21211 lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	U . S . A .	dian.		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "neturel", or iteme 23a or 28a-f show or other traumatic event, the Medical Evar, if we may be recitified at	þ	X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes XXX If Yes, Give Year or Dates:	lo	If Yes, specify Cuba 1 ☐ Yes 2 No		Rican, etc.)	Black, White, etc. Specify: Black 16b. Kind of Business/Industry			
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nd	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid					den Sumame)			
Maryland	2 should be f and Mental I Is marked of aumatic eve	L _O	John R. McLead 19a. Informant's Name/Relationship (Ty	no Grintl	405 14-7		Rosa Ki					
	1 and 2 si Health and em 27 is r ther traur		Willie Mae McEl		ister 39	ing Address (Street) 15 Callo	oway Ave,	Apt 20	ty or Town, State, Zip Code	Md		
Baltimore,	of Hez of Hez if item or othe		20a. Method of Disposition 1			osition (Name of matory or other place			Location - City or Town, S	15		
tim	oermit. Pages Department of t Importent: If its any injury or or once.		'4 ☐Donation 5 ☐ Other (Specify)		Arbutus	Memoria	al Park 5	5/12/05	Arbutus, M	ld		
Bal	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service License	Timp	$\stackrel{\circ}{\sim}$ $\stackrel{\circ}{\stackrel{\circ}{\sim}}$	2. Name and Addre arch F/E 300 Waba	ss of Facility I West ash Ave,	Baltimo	ore, Md 21	.215		
	*		23a. Part I, lighter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Approximate Interval Between Onset and Death Onset and Death									
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	CORS consequence of):	TRUCTI	VE LUN	32iQ D	ELA			
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oʻ	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or as a	a consequence of);							
8760,	eath certificate be executed attending physician and for use as the burial-transit	icai		l								
x 68	ding p	/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy							
.O. Box	0 O	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year			
Δ.	es that igned by	by Ph	Part II. Other significant conditions cor	o use contribute to the cau	se of death?							
ords	w require been sig should b		OBESITY tryp	OVENTI	LATION	SYNJ	DROME	1 ☐ Yes	2 No 3 Probably	4 Minknown		
l Records,	The la	Completed	DIABETES !	MELLI	TU S			24a. Was an autopsy performed	24b. Were autopsy fir prior to completic death?	on of cause of		
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	'agnital:		011	26. Place of Death	Check onl one)				
of	Phys this ral dii): To	1 Yes 2 No	ospital: 1 npatie	nt 2 ER/Outpatie		4 Li Nuising non	e 5 Residence	6 Other (Specify)			
	Attending I ir death. ector: After by the funer	atior	Natural 5 Pending investigation	(Month, Day	Year) Injury	Injury Mork?			iquiy occurred			
Division	iel or Attendii s after death. st Director: A sd in by the fu	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or within 24 hours after To the Funerel Dire	edical (29a. Certifier (Check only one) Check only one)	sicien: To the best of ner: On the basis of and manner sta	f my knowledge, deat examination and/or in led.	h occurred at the time evestigation, in my op	ne, date and place, ar pinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the ca	ause(s)		
	To the virthiin To the comp	Š	29b. Signature and title of certifier		Date signed (Month, Day, Y	'ear)						
9	11		1	- 6,	<i>(</i>)		54352	•	144,9,	1005		
L	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCLEA TODOIC NORTHWEST HOSPITAL THOLOLD COURT ROAD RANDALLSTOWN MD 21/33									
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 2005 32. Pigistrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per 11 - 7-05 vt.
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2005 8:51 Mary Bernadette

4a. Facility Name (If not institution, give street and number) Bernadette May ам 5 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 5013 Wilkens Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 17, 1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 K F Months 80 Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 United States 5013 Wilkens Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2XNo Yes, Give 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helena Mary Healy Otto Carl Angermaier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Metcalf / Daughter 1007 Linden Avenue, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 5/9/2005 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sonature Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) fibrillation cntricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 | Yes | 2 | No Wlipidemia 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📆 🖊 0

Physician /Medical Examiner

burial-tran

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director

After

after death. death.

24 hours

Within 2

Funeral Diracton eteky filled in by the

Medical

The law requires that the death certificate be executed

Box 68760

P.O.

Records.

Division of Vital

Hospital or Attanding Physician:

permit. Pages 1 Department of H Importent: If Its any injury or ot once.

Physician

/Medical

10a. State

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Itam 27 is marked other than "

Baltimore, Maryland 21215-0036

Director

Funera

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Completed

Be

traumatic avant, the Medical Examiner must be notified at

Examiner Physician/Medical by Be Completed 10 Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

27. Manne of Death

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

Other: 4 Nursing Home , 5 Sesidence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

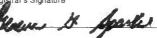
29c. License number 028236

rson who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

700 Gage Road Bult MD 21228 St. Martin mo 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar



28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please	Type or	Print in	Black	Indelible Ink.	Ensure	All (Copies	Are	Legible.
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10, 2005 John Charles McGeehan May 7:46 ΑM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 25, 1 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F 216-34-7214 Yrs. Director 67 1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md. Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 West Joppa Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental John Α. McGeehan 2 Catherine Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Itam 27 is any injury or other trav Mrs. Jayne H. McGeehan/Wife 1018 West Joppa Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 5/13/05 Timonium, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lon **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Dnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Tyes 2 No 1 🗌 Yes To the Hospitel or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA DSPICE this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAY 10, 2005 1)25205 uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md 21204 31. Date filed (Month, Day, Year) I 2. Registrar's Signature State MAY 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0606 AM 2005 /Medical 4c. County of Death 1014 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 HOSPIFAL 7. Age (In yrs. last birthday) BACTIMURE UNIVERSITE Decinlity 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours 314-50-3378 Usual Residence of Decedent 10M 20F Yrs. Director 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Directo** 10e, Street and Number 10g. Citizen of What Country? Items 23s or 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 🍂 w 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🖳 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Completed by White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2.should be filed withln nent of Health and Mental Hygiene ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) VOIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.:
Department of Health ar Important: If item 27 Is any Injury or other treu once. 20c. Location - City or Town, State Dai 20a. Method of Disposition

1 Burial 2 Scremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date remater ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the ral Fervice Licenses MidVallay Dr Jessup PA1843 23a. Part Thier he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease) if condition resulting in death)

Due to (or as a consequence of the condition of the condition). Approximate Interval Between Onset and Death Physician 15 MILULES /Medical Due to (or as a consequence of): Examiner heart disease 1040 Hyperatensive Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, renal Jeilure on Hemoelialysis 1 Yes 2 No 3 Probably 4 Unknown Completed mellims Diabeles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an venh lala pulmonary disease obstatie chmic clepentant | Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manne of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending investigation s after devel Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

trar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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University specifly hispital Gol south charles short

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Fune Direc			5. Social Security Number 255–12–7093			last birthday) Yrs.	If Under Months	1 Year If Und Days Hours	ler 24 Hrs. s Min.	8. Date of Bir (Month, Da March 31	th y, _{Year)} , 1920	Cou	place (State or Foreign ntry) Irgia
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e Man	Name of the last	ctor	MD Baltimore Pikesville									1 ☐ Yes 2 / ☐ No	
with th	4	Funeral Director	10e. Street and Number 2331 Old Coul	rt Road			10f. Zip	Code 21 208			10g. Citizen o		ntry?
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Saltimor	lury or		1	pecify)	MD	Veterans	s, Garr	ison Fore			Owings		
permit. Depart	any in		21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, ID 21204										Inc.
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DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After	completely filted in by the funeral director,	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	g Physicien: To the bes Exeminer: On the basis and manner s	of examina	owledge, death	h occurred vestigation	at the time, date in my opinion, o	and place, death occur	and due to the red at the time,	cause(s) and i	manner as s e, and due to	tated. o the cause(s)
To the Within	сошрі	_				- 41	290	. License numbe	9r		29d. Date sign	ned (Month,	Day, Year)
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101	X		29b. Signature and title of certified 30. Name and address of person Slovge E.	who completed cause of Wick & III	death (Iter	3900 3900	D Loc	h Rave	n Boi	ulavard	, Batti	move,	MD. 21218
Reg	Sta gistra		31. Date filed (Month, Day, Year) MAY 1 1	2005 Regist	trar's Signa	ture for	when						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** 2005 Ruth S. Matherly /Medical b. City, Town, or Leave de Grace

| Houre de Grace
| Houre 1 Year | Houre 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Houre Days | Houre Min. | 02/12/1916 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1000 Vurs. 12005 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2X F 89 Yrs. Texas Director 212-30-3224 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show digul Examinar must be notified at 1X Yes 2 □ No Director Harford Havre de Grace MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21078 144 Bloomsbury Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. 1 □Yes 2**X**No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 Yes 2 No land 21215-0036 Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry other than "natur 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private School 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Ith and Mental 27 Is marked of traumatic ever Regina Miller Frank Bahel P Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 N. Hickory Ave., Bel Air, MD 21014 f Health item 27 l Mark Carroll- Guardian other Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 05/04/05 Havre de Grace, MD Angel Hill Cemetery Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 S. Washington, Havre de Grace, MD 21078 Maure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enu WKS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, to amy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No this certificate Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To ŏ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. neral Director: A filled in by the fu investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lospital or Al 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D3260 3505 Winam. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

2005

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Milham Ms 1106 Revalution

32 Registrar's Signature

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			Registrar	Ce	rtificate of Dea		Reg. I	No.	lo Francisco
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Shirley Mary Mac	ccubbin				08 2005	3. Time of Death 21:34 M
	Examin	er	4a. Facility Name (If not institution, give street ar GOOD SAMPRITAN 140)	SPITAL	4b. City, Town, or Locati BALTIN	ORE		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 25	7. Age (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	urs Min. 8. t	Date of Birth Month, Day, Ye. 2pt. 20,	9. Bin 1927 Ma	nplace (State or Foreign untry) TYLAND
	Inyland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le		-			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Modical Exactilistic and Le ricilified at Once.	/ Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Arm 1 Never Married	s Decedent Ever in U.S. 13. led Forces? Yes 2 X No es. Give	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 No Spec		Yes or No- in, etc.)	14. Race - Ame Black, Whit	e, etc.
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and 2	t be filed ntal Hyg ed other: event,	To Be C	17. Father's Name (First, Middle, Last) Frederick W. Bruni.	er	18. M	Mother's Name (Fit Lillia		ien Sumame) ČNS Z	
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THE REAL PROPERTY.	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	that caused the death. Do not ene on each line. PSTS ue to (or as a consequence of):	nter the mode of dying, such	h as cardiac or rθ	spiratory arrest,		Approximate Interval Between Onset and Death
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely tilled in by the funer	edical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, dean the basis of examination and/or it displays the displays the basis of examination and/or it displays the basis of examination and the basis of ex	ith occurred at the time, dat nvestigation, in my opinion,	ite and place, and , death occurred a	due to the caus at the time, date	e(s) and manner a and place, and due	s stated. to the cause(s)
)	To the within 24	Med	29b. Signature and title of certifier	AN M.D	29c. License num RES			Date signed (Moni	
	10		30. Name and addless of person who complete	od cause of death (Item 23a) (Type		AN HO	SPITA	L.	
No.	Sta Regist	ate	31. Date filed (Month, Day, Year) MAY 1 1 2005	32 Pegistrar's Signature					
DH	MH 17 Rev 1/2		mr. 1 1 2003	Blanc & A					

			1 - For State Registrar			and / Depa		t of H	ealth a		•		2005	158	99
			Decedent's Name (First, Middle,	Last)						_	2. Date of D			3. Time of	Death
П	Physicia		David Barry Moo	re. Sr.							Month Mav	0.7	Year 2005	4:25	рΜ
	/Medic Examin		4a. Facility Name (If not institution,		umber)		4b. City,	Town, or	Location of	of Death	riay		County of Deat	h	
Н		-	Gilcrest Center				Tows	son				Ва	1timore		
	Funeral			. Sex		rs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth av. Year)	9. Birti	hplace (State of untry)	r Foreign
	Director		216-50-3146	1ØM 2□F	55	Yrs.					01-14-	1950	Mary	land	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c	City, Town or Lo	ocation							10d. Inside Cit	tv Limits
	sho	5	,											1 🗆 Yes	
	the N	ect	MD Balt:	Lmore	B	altimore	10f. Zip		ds			10a Citi	zen of What Co	untov?	
	with a or	Funeral Director	3019 A Louisiana	a Ave				1227				U.S		unity.	
	leeth	era	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13.			ispanic Ori	igin? (Spi	ecify Yes or N		14. Race - Ame	rican Indian,	
0	r tten	ᇤ	1 ☐ Never Married 2 ☒ Marrie	Armed 1177 Yes	Forces?						ecify Yes or N Rican, etc.)		Black, White		
ğ	el', o	by	3 Widowed 4 Divorced	If Yes, 0 Year or	Dates: 86-	93	1 ☐ Yes	2⊠ No	Specify:				Specify: Whi	te	
21215-0036	within 72 hours after deeth with the Maryland ene. Than "naturel", or items 23a or 28e-f show he Madical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	d)	16a. Dece	dent's Usua kind of wo	al Occupa	ation during mos	t of work	ina	16b. Ki	nd of Business/	Industry	
2	ithin 19.	npi	Elementary/Secondary (0-12)		(1-4or 5+)		kind of wo DO NOT u	se retired)		3				
N	ygier ygier her th	ខ				Carpe	enter		40 14-41-4	- d- 81	(First Adiabat)		structi	on	
בַ	be fill d oth even	Be	17. Father's Name (First, Middle, La Richard Moore	ist)					Dori		First, Middle	e, Maiden	Sumame)		
2	2 should be filed within 72 hours after deeth with the Marylan and Mental hygiens is marked other than "naturel", or items 23a or 28e-f show is marked other than "naturel", or items 23a or 28e-f show aumstic event, the Madical Examiner must be notified at	٦	19a. Informant's Name/Relationshi	Tuna Print		10h Maili	ng Addross	(Stroot :				har City o	Town, State, Z	Zin Code)	
Maryland	os 1 and 2 should b of Heelth and Ment I item 27 is marked r other traumatic e		Cathy S. Moore/V			1	•				altimo:			ip Code)	
d)	Heelth Heelth tem 27 other tr		20a. Method of Disposition		20	b. Place of Dispo cemetery, cre	osition (Nar	ne of	-1		Date	20c. Lo	cation - City or	Town, State	
OF.	permit. Pages 1 Department of H importent: If Ite any injury or ot ang.e.		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			сөтөтөгү, сгө. Bayview				5-10	-2005	Balt	imore,	MD	
Baltimore,	artme orter injur		21. Signature of Funeral Service Li		1100	2	2. Name ar	d Addres							
ñ	Depa impo any ir		> SUGA to	Alla	12	2	7150	lammo	inera.	Ferr	ne Rdi 1	lansd ansd	owne owne MD	21227	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications tha	caused the d	eath. Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Bety	a ween
	Pnysician ₁		Immediate Cause (Final disease or condition	-		ritic	Can	(pr						Onset and C	Death
	/Medical		resulting in death)		o (or as a con									00(0.0)/	
	Examiner	.	Sequentially list conditions.	b											
T	p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a con:	sequence of):									
V	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a con	sequence of):									
760,	ate be executed hysicien and the burial-transit	calE			0 (01 40 4 001)	304301100 017.	•								
687	icate phys s the			d											
Box	death certificat e attending phy of for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		7-					2	23d. Date of deli	ivery	
ŏ	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2 □ F gnant at time		∃Ectopic pi ∃ Other (sp						Month	Day Y	/ear
0.0	t the by the tache	hys	9 ☐ Unknown	9□ Uni	cnown										
	The law requires that the de ate has been signed by the a page 2 should be detached l	by Physician/Med	Part II. Other significant condition	s contributing to	death but not	resulting in the u	inderlying o	ause give	en in Part I		. A.		se contribute to		
d	en si ould I	De de									100	Yes 2	□No 3□Pr	obably 4 □U	Inknown
Records,		ple									24a. Wa	opsy ,	prior to 0	topsy findings a	available ause of
	Physician: The la r this certificate has	Completed									perl 1 ☐ Yes	2 No	death?	2□ No	
Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital				Oth			h (Check only		V	1/20/02/2	
of	Physic this c	T0	1 ☐ Yes 2 No 27. Manner of Death			2 ER/Outpatie			4 🗆 140		me 5 Res 28d. Describe		/	city) MOJO II	q
LO	ding h. Afte fune	tlon	1 → atural 5 ☐ Pending		te of Injury onth, Day Yea	r) Injury	M	28c. Injun Worl	k? Yes 2. ☐		200. 00301100	TION IN I	. C. Sulling		0.50
Division of	Attending Physician: r death. ector: After this certifice by the funeral director, t	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Pla	ce of Injury - A	At home, farm, st							d Number or Ru	ıral Route Numi	ber,
2	To the Hospitel or Attenc within 24 hours efter death To the Funerel Director: completely filled in by the	Certification:	4 Homicide	bui	lding, etc. (Sp	ecify)					City or To	own, State,)		
	Hospite 24 hours Funerei etely filled		29a. Certifier Certifying	Physician: To t	he best of my	knowledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	e cause(s)	and manner as	stated.	1
		ledical	one)	and ma	anner stated.	IIIIation and of it				IN OCCUM	ed at the time				
	To the within To the comple	Σ	29b. Signatule and title of certifier	1			290	c. License	e number	2			e signed (Monti	n, Day, Year)	
			you	ww	2			US	836	7 2		IV (I)	489	40)	
	3		30. Name and address of person w	ho completed ca	use of death (IJem 23a) (Type,	Print)	110	10 (0)	(BA	MA	Ne MA	25150	24
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Si		0,0	JV 4	VUO.	1 0	1200	- VIV	USC NO F		-
	Registr		MAY 1 1	2005	Epilica e	1. do	de								

DHMH 17 Rev 1/2001

Moscre David May 7,2005 4:25p.m

			1 - For State Registrar	State of M	aryland			t of H	ealth a				9.5	15900
	Physici	an	1. Decedent's Name (First, Middle, La William Le	st) eon Mason	n						2. Date of Dea Month May 5,	th PAY	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gives 5016 Spearfish	e street and number)				Town, or .dorf	Location of		may 5,	4c. Cour	nty of Death	10:15AM M
	Funeral Director		0.7 0.7.0	ex 7. Ag	78 78	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day NOV 11,	1926	9. Birth Cap Wash	place (State or Foreign ntry) ington DC
	yland 10W		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						T	10d. Inside City Limits
	r 28a-f show	Director	Maryland Charles			Wald	orf							1 ☐ Yes 2∭XNo
	23a or 21	rai Dire	10e. Street and Number 5016 Spearfis	h Place			10f. Zip	206	03			Og. Citizen o United		•
920	72 hours after death with the Maryland "natural", or items 23a or 28a-f show Greal Examinations is a modified at	by Funerai	11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Dyes 2 If Yes, Give Year or Dates:		4	Vas Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		ace - Ameri lack, White, cify: B1	
21215-0036	- 3	Completed	15. Decedent's E (Specify only highest gra			16a Deced	lent's Usua kind of wor	l Occupa k done di	tion uring most	of workin	gD.C.	16b. Kind of	Business/Ir	dustry
212	d within jiene. r than "	dwo	Elementary/Secondary (0-12)	College (1-4or !	5+)	Sanit	ation	Dep	ent artme	nt I	Public Works	Civil	Serv	ice
Maryland 2	permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hyglene. Important: if item 27 is marked other then 's my injury or other traumatic event, Ite Magnes.	To Be C	17. Father's Name (First, Middle, Last, UNKNOWN		,					's Name	(First, Middle, I		ame)	, - ,
	and 2 sho		19a. Informant's Name/Relationship (Teri Hines(Daugh			19b. Mailin 501	g Address 6 Spe	(Street a	nd Number sh Pl	or Rural	Route Number Waldor	f, Md	n, State, Zij 20603	Code)
Baltimore,	Pages 1: nent of He ant: If itan ury or oth		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	Ce	ace of Dispos metery, crem land	natory or of	her place		ау Î ⁵ 2005	1.	^{20c.} Location Chelte	-	own, State Maryland
20a. Method of Disposition 1 Description 20a. Method of Disposition 1 Description 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Colors 22. Name and Address of Facility Lee Funeral Alexandria Ferry Rd, Clinto														
	Pnysician /Medical		23a. Parl 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li	ne.	Do not ente					respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner		ſ	Due to (or as	a conseque	ence of):							1	
8760,	certificate be executed iding physician and ise as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
687	tificate ng physias the	ledica		d			-							
О. Вох	that the death certific ed by the attending p detached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe						ate of delive	Day Year
ds, P.	gn gn	by	Part II. Other significant conditions o	ontributing to death b	ut not resul	ting in the un	derlying ca	iuse giver	n in Part I.					ne cause of death?
Records,	he law requir e has been si sge 2 should I	Completed			-					_	24a. Was ar autops perform	v	Were auto prior to con death?	psy findings available appletion of cause of
	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical						26. Place o	of Death	1 Yes 2	DNOT	1 🗆 Yes	2 No
of V	shys this al dir	2	examiner?	Hospital: 1 Inpatie		R/Outpatient		Other	4 🗆 Nurs	sing Hom	e 🏋 Reside	nce 6 □Ot		1)
	th. : After funer	tion	27. Manner of Death 1 THatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Da)	ry Year) 2	28b. Time of Injury	28 M	lc. Injury a Work?	at es 2⊡No		3d. Describe ho	w injury occu	rred	
Division	al or Attandii s after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury · At hom c. (Specify)	ne, farm, stre	et, factory,	office		28	3f. Location (Str City or Town	reet and Num , State)	ber or Rura	l Route Number,
:	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier	ysician: To the best of liner: On the basis of and manner sta	examinatio	ledge, death on and/or invi	occurred a estigation,	t the time	n, date and nion, death	place, an	nd due to the ca d at the time, da	use(s) and m ite and place	anner as st , and due to	ated. the cause(s)
	com (M	29b. Signature and title of certifier	M Mce	tli		29c.	License	number	7	29	Od. Date signe	od (Month,	Day, Year)
16	XX		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, F	Print	fe		1	V) ,	701	64	6
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1	32. Regista	ar's Signatu	H.	boul							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MCLAUGHLIN Day Year **Physician** Month 2005 GLABTS 30 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort washington MD 20744 Fut washington
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1□M ZQF 448 50 3909 Director March 30,19080klahoma Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f ehov traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√1No Director Marvland Prince George's Accokeek 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 913 Bryan Point Road 20607 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give A
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elem. School permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or othar traumatic event 900.6. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bert Bradlev Avis Kirkman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeEtta Townsend (Daughter) 913 Bryan Point Road, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2) Cremation 3 ☐ Removal from State Lee Crematory May 8, 2005 ' 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Line 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 100193 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Domentia **Physician** /Medical Due to (or as a consequence of) Examiner Anterio sclentic heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Arteriscoloration Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 500 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Day, Year) 932506 who completed cause of death (Item 23a) (Type, Print) 1701 Livington Road, Fort WASHington ANNER MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State of Registrar	Maryland /	-	rtment o			nd Ment		iene	05	15902
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) TOYIA M MANNA						N	ate of Dea Month	Day	Yeer 005	3. Time of Death 1708 P M
	Examir	er		nber) VIEW Med 7. Age (In yrs. last b	dCtr	4b. City, To Bad If Under 1	trn	ocation of	,	ate of Birth		nty of Death	plece (State or Foreign
	Funeral Director		215-84-3523 Usual Residence of Decedent	35	Yrs.		Days	Hours	Min. (A	ate of Birth Month, Day 12/10		MD	intry)
	e Maryland e-f show	ctor	10a. State 10b. County MD Baltimore City	10c. City, Tov		ation							10d. Inside City Limits 1 Yes 2 No
	with th	Directo	10e. Street and Number			10f. Zip Co					0g. Citizen	of What Cou	intry?
30	tiled within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23c or 28e-f show with the Mydical Examinar rust be mydified at	by Funeral	Armed Fo	2 🔽 No	1	2122 /as Deceden Yes, specify	nt of Hisp Cuban,	panic Origi , Mexican, Specify:	in? (Specify) Puerto Ricar			Race - Ameri Black, White	, etc.
9500-6121	vithin 72 hour ne. han "natural" s Medicul Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give ki	ent's Usual C tind of work of O NOT use	Occupati done du retired)	ion ring most o	of working		16b. Kind of Own Ho		
7	filed v Hygie other t	e Co	8 17. Father's Name (First, Middle, Last)	H	omema	aker	1	8. Mother	s Name (Firs	st, Middle, i	Maiden Sum	ame)	
yland	should be ind Mental i marked c	To B	Edward F. Lowell					Juani	ta R.	McCau	ley		
Mar	d 2 should hand 7 is m		19a. Informant's Name/Relationship (Type, Print) Michelle Hoffman /Sister		_				or Rural Rou		•		p Code)
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumatic		20a. Method of Disposition	20b. Place cemete					Baltin	-	20c. Locatio		own, State
ıtımore,	ritt. Pages cartment of cartent: If its injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5 ☐ Other (Specify)	DIAIN _	_				May nc. 200	10	Beltsv	ille,	Maryland
Hair	Departition Department of the perturbation of		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that c	M00986	27 87	717 Gre	on ar een l	nd Fui Pastui	neral A res Dri	ve B	altimo		ryland 2128 Approximate
	Physician /Medical		shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	ach line. ntilator or as a consequence	r as						-		Interval Between Onset and Death 2 weeks
	Examiner	er		rokic bro		inju	uru)					
8/60,	ate be executed only sician and the burial-transit	ical Examiner	that initiated events	or as a consequence		eun	201	ria					
). BOX 68/	auth certific attending p for use as	Physician/Medic	in the past 12 months?	come of pregnancy rth 2 Fetal deat ant at time of death		Ectopic prega Other (speci						Date of deliv	ery Day Year
ds, P.C	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to de			-		in Part I.	2	23e. Did tol			the cause of death?
II Records,	The lay ate has page 2	Completed	, ,							24a. Was a autops perform	y	prior to co death?	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner?			•500			of Death (Che		-/		
lon or	ng Phy: fter this ineral d	ation: To	27. Manner of D ath 28a. D te d		Time of Injury		. Injury a Work?				ance 6 ∐C		fy)
DIVISION	iel or Atte s after de al Directo ed in by th	Certification:		of Injury - At home, f ig, etc. <i>(Specify)</i>	farm, stree	et, factory, o	office			ocation (St City or Town		mber or Run	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the band mann	sis of examination a	ge, death o ind/or inve	estigation, in	my opir	nion, death	place, and di occurred at	the time, d	ate and plac	e, and due t	o the cause(s)
	To I To I	N N	29b. Signature and title of certifier	Lelan			icense r		1	2	9d. Date sign	ned (Month,	Day, Year)
0	15		30. Name and address of person who completed caus	of death (Item 23a)) (Type, P		22.	500			, vui	70,	2005
A	11	10	31. Date filed (Month, Day, Year) 32. R	4940 E	aste	VI A	ven	ve, E	Baltzi	nort	, MD	216	4
	Sta Registi		31. Date filed (Month, Day, Year) 32. R MAY 1 1 2005	Bloom !	D. 1	N. S.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State o	f Maryla		artment of I	Health and M Death		jiene		15003
	Physici		Decedent's Name (First, Middle		Edward	McCle	llan		2. Date of Dea Month	th	Year	3. Time of Death 4:30pm M
	/Medi Examir		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town,	or Location of Death	Tay ,	4c. County of	f Death	
			Greater Baltimo				Towson			Baltim	ore	
	Funeral Director		5. Social Security Number	6. Sex •★□ M 2□ F		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign htry)
			219-38-1142 Usual Residence of Decedent		64				Nov. 1	7,1940	Mar	cyland
	show		10a. State 10b. County		10c. C	City, Town or Lo	ocation				1	0d. Inside City Limits
	8a-f s	Director		Baltimore				Colgate				1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	hat Coun	itry?
	ns 23	Funeral	7839 Gough S	treet 12. Was Dece	dent Ever in	U.S. 13		21224 Hispanic Origin? (Soc	acify Ves or No-	United		ces can Indian,
< 9	after o	Fun	1 ☐ Never Married 2 € Marri	Armed Fo	rces?			Hispanic Origin? (Spe pan, Mexican, Puerto	Rican, etc.)		, White,	etc.
∑ 003	thin 72 hours after death with the Maryland e. an "natural", or Items 23a or 28a-f show Medical Examil at must be notified at	d by	3 Widowed 4 Divorced	If Yes, Giv Year or D	atae.	tnam	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Wh	nite
35	n 72 h	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of worki	ing	16b. Kind of Bus Baltimo		
, 212	E 2 2 3	omp	Elementary/Secondary (0-12)	College (1			enior Med	-,		& Elect		
∑ p	be filed vital Hygie	Be C	17. Father's Name (First, Middle, I	ast)		St	suror Mec	18. Mother's Name)	
) ylar	2 should be and Mental is marked o aumatic eve	To	Guy Edward M	cClellan				Doro	thy Crot	hers		
CC/C/AN	ges 1 and 2 should be it of Health and Mental it item 27 is marked o or othar traumatic eve		19a. Informant's Name/Relationsh		,			and Number or Rura				Code)
() ()	s 1 and if Health item 27 other tr		Mrs. Christin	a McClell			Gough S		ltimore,			21224
ပ်ဋ်	ages ant of t: If it		1 ☐ Burial 2 ☑ Cremation		State	cemetery, crei	natory or other pla	ce)		20c. Location - C		
altic	- E E C .		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service t		Hi		Service C 2. Name and Addre	Corp. 5/11, sss of Facility	/2005	Towson,	Mar	yland
B	permi Depa Impo any ir		Ventir a	loner		I	ouda-Ruck	Funeral Ave. Dur	Home of	Dundalk	, In	IC.
			23a. Part1. Enter the disease or shock, or heart failure. List of	complications that conly one cause on e	aused the dea	ath. Do not ent	er the mode of dyi	ng, such as cardiac o	r respiratory arre	est,	71	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	M	las-	totec	Lux	Carcin				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	1					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a cons	guence of						
V	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.								
ó,	e exectian an	Exa	resulting in death) Last		or as a conse	quence of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9		/Me	IF FEMALE:	23c. if yes, out	come of pregr	ancy			····			
Вох	death certif attending d for use a	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live bi	irth 2 ☐ Fet ant at time of	tal déath 3 □	Ectopic pregnance Other (specify)	у		23d. Date Monti		ry Day Year
P.O.	that the deatl ed by the atte detached for	hysi	9 Unknown	9□ Unkno								
S, F	နှင့် မွေ	by Physician/Me	Part II. Other significant condition	ns contributing to de	ath but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	ute to the	e cause of death?
ord	w require been si should								1200	s 2 No 3	☐ Proba	ably 4 □Unknown
Division of Vital Records,	e law has b	Completed							24a. Was an autopsy	24b. We	re autop	osy findings available inpletion of cause of
al F	ysician: The lis certificate hadirector, page								perform		th? Yes	2□ No
×.	sicial s certi	o Be	25. Was case referred to medical examiner?	Hospital:	7 2001 00 00	☐ ER/Outpatien	Oth	26. Place of Death				
of	ding Phys h. After this funeral di	-	27. Manger Death	28a. Date		28b. Time of	t 3 DOA 28c. Injur	4 U Nursing Hom	ne 5∐ Residei 28d. Describe ho)
io	Attending or death. ector: After by the funer	atio	Natural 5 Pending investigation	ation	i, Day rear)	Injury		Yes 2□No				
<u> </u>	al or Attend after death Director: /	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Place	of Injury · At h	nome, larm, stri ify)	eet, lactory, office	2	281. Location (Str. City or Town,	eet and Number State)	or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to		29a. Certifier Certifying	Physician, To the	baat of multon							
	e Hos 24 ho e Fun etely	edical	(Check only 2 Medicel E	xeminer: On the ba and mann	sis of examina	ation and/or inv	estigation, in my o	me, date and place, a pinion, death occurre	and due to the ca and at the time, da	use(s) and mann te and place, and	er as sta d due to	ited. the cause(s)
	To the within 2 To the Complex	Me	29b. Signature and title of certifier	. 1		-	29c. Licens	e number	29	d. Date signed (Month, D	Jay, Year)
			land	Al ac	Q0 1	no	0	26835		5/8/	25	
-	141		30. Name and address of person w	no completed cause	o ol death (Ite			Meion		2.0	- Contract of the Contract of	
	5+1		31. Date liled (Month, Day, Year)	aul J	ogistra Sign	656	1 9V.CO	Alles S	Thee!	pally	brc	MID 2120
	Sta Registra	-	MAY	1 1 2005	gistraffs Sign	w St.	perte	•				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name /First Middle Last 2. Date of Death Month Day **Physician** May 6, 2005 4:15 AM Christine B. Maass /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carriage Hill-Bethesda Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 ☐ M 2 🗓 F 304-03-2206 96 Director June 10, 1908 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, the Medical Exaction remail terminified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 7809 Custer Road 20814 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ Year or Dates: 3 X Widowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi Emil O. W. Swanson Matilda Liljeblad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Pinehurst Road P.O. Box 237
Marshfield Hills, Massachusetts, 02051 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 4s n Peter Swanson / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 11, 2005 ö Bethesda, Maryland * 4 □ Donation 5 □ Other (Specify) injury 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. any ir M01420 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Infarction /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2X No 1 ☐ Yes 2 ☐ No. To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🎇 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mo, MA D0057124 517105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #201, Rockville, Maryland 20850 Truong Bao, M.D., marke 32. Regis Ar's Signature 31. Date filed (Month, Day, Year) State 2005 ▶ Registrar

			1 - For State Registrar	State of Ma	ıryland / Depa <i>Cei</i>	artment of F rtificate of		, ,	iene og. No. 2 1 1	5 15000				
	Physici /Medio		Decedent's Name (First, Middle, Last, I	Bessie E.	Magruder			2. Date of Dea Month May	7, 2005	3. Time of Death 12:10 PM				
	Examir		4a. Fecility Name (If not institution, give 1024 Paul Drive			Rockvi			4c. County of E					
	Funeral Director		5. Social Security Number 6. Sec. 212-20-1269	7. Age	(In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9. 1907 T	Birthplace (State or Foreign Country) ennessee				
	e Maryland 8a-f ehow utilied at	ctor	10a. State 10b. County Maryland Montgome	ry	10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No				
	eath with th	Funeral Director	10e. Street and Number 1024 Paul Drive	12. Was Decedent E	har in H.S	10f. Zip Code 2085			Og. Citizen of What	ates				
900	ours after d rai', or iterr Examinar	by Fund	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟፟ Midowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:	0	was Decedent of H f Yes, specify Cuba I ☐ Yes 2 \$\text{\text{M}} No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		mencan Indian, Thite, etc. White				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28a-1 show enty injury or other traumatic event, Va Medical Examinar must be notified at once.	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Busine					
Maryland 2	buld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) James Wilder					ne (First, Middle, M Fergursor	Maiden Sumame)					
	1 and 2 sho Health and Iam 27 ie m		19a. Informant's Name/Relationship (Ty Bernice G. Morrise 20a. Method of Disposition		er 20229	Grazing	Way, Montg	gomery Vill	City or Town, State age, Maryla 20c. Location - City	and 20886				
Baltimore,	permit. Pages Department of Important: If i Iny injury or once.		1		Parklawn Mer		200	11, 05 R		, Maryland				
	**) 		23a. Part1. Errer the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused	the death. Do not ente	West Mont	gomery Ave	or respiratory arre	ille, Maryl est	Approximate Interval Between Onset and Death				
	Physician /Medical Examiner	disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions												
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, loacing to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):									
.O. Box 6	The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year				
Records, P.	w requires that been signed I should be det	by	Part II. Other significant conditions con	tributing to death bu	not resulting in the un	derlying cause give	en in Part I.	23e. Did tob		o to the cause of death? Probably 4 ☐Unknown				
		Completed							led? death X¹No 1 □ Y	autopsy findings available to completion of cause of ? es 2 ☐ No				
Division of Vital	Jing Phys	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Yes H 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day		28c. Injury Work	er: 4 🗋 Nursing He	th (Check only one one 5 K Reside 28d. Describe ho	nce 6 Other (S	pecify)				
Divis	oital or Attendurs after death	Certification;	3 Suicide 6 Could not be determined	building, etc.				City or Town	State)	Rural Route Number,				
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier Certifying Phys (Check only one) 2 Medical Examin	and manner state		estigation, in my or	oinion, death occur	red at the time, da	te and place, and d	ue to the cause(s)				
1	1		30 Name and address of person who co	MUNI E	ath (Item 23a) (Type, F	Print)	36246	7 /	5/9/05					
-	Sta Registra		Robert W. Olwin. 31. Date filed (Month, Day, Year) MAY 1	32. Registrar	Signature St	ndg La	Ste LZ	Drock	yn Far	MD 2/225				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2005 Constance Rose Manson 5, АМ May 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 4. April 28, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) , 1920 Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Director 207-07-0386 85 Yrs Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "netural", or Items 23e or 28e-f ahow the Medical Examinar must be notified at 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Adclare Road 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "netural, or Iten any injury or other traumatic event, the Medical Examples once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry R. Rich Minnie Vitale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry A. Rich/Brother 7418 Spring Valley Drive, #519, Springfield, VA. 22150 20b. Place of Disposition (Name of cometery, crematory of other place)
Darnestown Presbyterian 20a. Method of Disposition 20c. Location - City or Town, State May 9, 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Gaithersburg, Maryland 2005 Church Cemetery 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Englished by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardio Vascular Accident /Medical Due to (or as a consequence of): Examiner Heart Failure Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be Chronic Intestinal Obstruction 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2X No tha Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 💢 No this (1 Inpatient 2 ER/Outpatient 3 DOA After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours are: ___ To the Funeral Director: A death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 27830 ナハ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Ramleath Shakir, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9019 Shady Grove Court, Gaithersburg, Maryland 20877

- 3151		1- For Unpend Item 2 Registrar	State of Maryland 3a&27 per me	G843 5-25-05 t Certificate of L	ealth and M Death	lental Hyg	iene .g. % 005	15907
Physi /Med		1. Decedent's Name <i>(First, Middle, Last)</i> EVa	Marie	Nelson		2. Date of Deat Month		3. Time of Death
Exam		4a. Facility Name (If not institution, give str 101 CENTER PLACE	APT. # 305	DUNDALK			4c. County of Death BALTIMORE	
Funera Directo		5. Social Security Number 212-88-8537 Usual Residence of Decedent	7. Age (In yrs. Ia: 444	Yrs. If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan4, 1		
Maryland	tor	10a. State 10b. County	imore 10c. City,	Town or Location Dundalk			1	0d. Inside City Limits 1 ☐ Yes 3 ☐ No
h with the M 38 or 28e-f	al Director	10e. Street and Number 2021 Jasmine R	load	10f. Zip Code 212	2.2	10	Og. Citizen of What Coun	try?
036 vurs after death w al', or Items 23e	by Funeral		. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar		cify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White,	
and 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. Indicate then "natural; or Items 23e or 28e-f show event, the Medical Examination or other the modified and the modified of the modified and the modified of the modified o	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Home Make	uring most of workin	ng 1	Own Hom	•
E ed la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last) Kenneth George N	_		18. Mother's Name Mary Ja	ne Ada	ms	
Ta leal		19a. Informant's Name/Relationship (Type Mary Jane Reuwer 20a. Method of Disposition	/Mother	19b. Mailing Address (Street at 101 Center 1 e of Disposition (Name of	Place Ap	t 305	Balto., M	d 21222
Baltimore, permit. Pages 1 at Department of Hea Importent: If item any injury or other		1 Burial 2 Cremation 3 Ren '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	noval from State	view Crematory 22. Name and Address	ory 5/10 ory 5/10	0/05 B	altimore, i Funeral imore, Md	Md. Home, PA
Carbon by the bright of the principle of the physicien and bright of the	edical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		ic cardiovascu				Approximate Interval Between Onset and Death
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnancy Live birth 2 Fetal de Pregnant at time of deate Unknown	ath 3 Ectopic pregnancy			23d. Date of deliver Month	y Day Year
ords, F	þ	Part II. Other significant conditions contril	outing to death but not resulting	ng in the underlying cause giver	n in Part I.	T .	acco use contribute to the	
Vital Reco	e Completed	25. Was case referred to medical					prior to com death? No 150 Yes 2	sy findings available pletion of cause of
on of ding Phys After this funeral di	Certification: To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		Outpatient 3 DOA Other. Time of Injury M M Other. Other. Other. Work?	at 28	e 5 🗌 Residence 8d. Describe how	ce 6 Other (Specify) injury occurred et and Number or Rural	SCENE Route Number,
Division To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Exeminer	an: To the best of my knowle On the basis of examination	dge, death occurred at the time and/or investigation, in my opir	, date and place, an	due to the ear	00(0) and magnet as also	red.
To the within 2 To the comple	Med	29b. Signature and title of certifier 29b. Name and address of person who comp	X. A	29c. License r	number ME	29d	MAY 7, 2005	ay, Year)
St: Regist		THEODORE M. King 31. Date filed (Month, Day, Year)	32. Register's Signature	a) (Type, Print) 111 Penn	Street I	Baltimor	e, Maryland	21201

			1 - For Stata Registrar	State of Marylar	•	artment of F			giene neg2noD 0 5	15908
			Decedent's Name (First, Middle, Las	it)				2. Date of Dea	uth	3. Time of Death
ı	Physici /Medic Examin	al	Elisabeth 4a. Facility Name (If not institution, give	S.		Plitt 4b. City, Town, o	or Location of Deat	Month May	Day Year 10, 2005 4c. County of Deat	9:30AM ^M
		CI	9 Gray Drive 5. Social Security Number 6. So	ex 7. Age (In yrs.	last hirthday)	Pasad If Under 1 Year	lena If Under 24 Hrs	. 8. Date of Birth	Anne Ar	undel hplace (State or Foreign
	Funeral Director			M 2₽F 65	Yrs.	Months Days	Hours Min.	(Month, Day	2,1939Pen	untry)
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl a-f sho	tor	Maryland Anne Ar	undel Pa	asadena	a				1 ⊡Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	ath w		9 Gray Drive				122		U.S.A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic svent, it is Medical Evaluational to notify daily or other traumatic svent, it is Medical Evaluational to notify daily.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 ☐ No	dispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	Specific	
9	72 hounanatura		15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occup	pation	rking	16b. Kind of Business/	Industry
21	nithin 7 0e. han "r	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)	life.	DO NOT use retire	d)	9	C	/1 d
d 2	Hygie Hygie other ti		17. Father's Name (First, Middle, Last)	4	Bud;	get Analy		me (First, Middle.	State of N Maiden Sumame)	Maryland
Baltimore, Maryland 21215-0036	2 should be fited within and Mental Hygiene. Is marked other than aumatic svent, Ite M.	To Be	William Fre	ederick Sch	oenhut		Ethel			Downs
lan	2 sho and Is me	14	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number	r, City or Town, State, 2	(ip Code)
e, r	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trae		William E. Plitt 20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		a, Mary <u>l</u>	and 21122 20c. Location - City or	Town, State
บดูเ	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	natory or other pla	! _ /-	1/05	Baltimore	
ali:	mit. P partme sortan / injur		21. Signature of Funeral Service Licen			Crematory Name and Addre			ome, P.A.	Maryland
ä	permi Depar Impo any ir		John Fi	Collins	3	204 Mount	ain Road	Pasaden	ome, r.a. a, Maryland	1 21122
			23a. Part. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat one cause on each line.	th. Do not ent	er the mode of dyin	ng, such as card	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	te M	it could	ual d	March	011	
П	Examiner			b.	(derice of).	0		1		
	De is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsec	uenca of)-					
	cate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):				-	
8760,	ate be only sicial he buri	dicail		d						
9	aath certifica attending pl for use as t	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Date of del	
P.O. Box	the the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)	y		Month	Day Year
s, P	ires that the signed by do be detact	by Pr	Part II. Other significant conditions of	entributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	v requir	eted	- n gpa	9 00000				24a. Was a		
al Rec		Completed						autops perform 1 ☐ Yes	sy prior to death? 2⊠No 1 □ Yes	topsy findings available completion of cause of
ž	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	nt 3 DOA Ott	100	ath (Check only or	ence 6 □Other (Spec	764)
n of	ing Phy After this uneral d	ion: To	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	ry at	-	ow injury occurred	,ny,
Division of Vital Records,	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str fy)		195 2 110	28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edical C		ysicien: To the best of my kno niner: On the basis of examina and manner stated.						
	To th within To th	**/	29b. Signature and title of certifier	1	1	29c. Licens	- 1		29d. Date signed (Month	n, Day, Year)
	11/		A A CO	J		1	5047		5/10/05)
1	C*		30. Name and address of person who of SRID HAR. AT I	NR ; 8100	1 Ri	Print)	Highwa	y; Porc	rolema, MI	21122
	Sta Registr		31. Date filed (Month, Data (14))	1 20052. Registra Signa	ature 5	A STATE OF THE PARTY OF THE PAR				

		1- State Unpend Item 2	State of Marylar 3a&27 per me				Mental H	ygiene Reg. No	•	15909
Physic /Med	ical	1. Decedent's Name (First, Middle, Last) KATHLEEN D. POOLE					2. Date of D MAY 3	, 200		3. Time of Death 8:13 P M
Exam	iner	4a. Facility Name (If not institution, give s 6701 HIGHVIEW AVE	treet and number)		O'	, Town, or Location of De /FRLFA		В	County of Deat	
Funera Director		5. Social Security Number 212-82-2440 Usual Residence of Decedent	7. Age (In yrs. 46	last birthday) Yrs.	Months	r 1 Year If Under 24 H Days Hours M		1958	9. Bird GEF	hplace (State or Foreign puntor) KMANY
Maryland -f show	tor	10a. State 10b. County Maryland Baltimor		ty, Town or Lo		erlea ~ Bal	timore C	ounty	,	10d. Inside City Limits 1 ☐ Yes 2 X No
with the	Directo	10e. Street and Number	110		10f. Z	p Code 21206			izen of What Co	ountry?
idryidilid Z IZ 13-UU30 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f show aumstic event, tre Madical Examiner must be notified at	by Funeral	6701 Highview Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes, XX No If Yes, Give Year or Dates:		Was Deci If Yes, sp 1 Yes	dent of Hispanic Origin? ocify Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	1	14. Race - Ame Black, Whit Specify: Wh	e, etc.
thin 72 hours nature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	kind of w DO NOT	nal Occupation ork done during most of vise retired)	vorking		ind of Business/	Industry
Maryland 21215-UU30 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Madical Exam	Be	12 yrs. 17. Father's Name (First, Middle, Last)	2 yrs.	0pt	cicia	18. Mother's N	ame (First, Middle	le. Maiden	,	
Marylis 12 should and Mer is marke	To	Oswald Palombo 19a. Informant's Name/Relationship (Typ. Bernardine Palombo			-	s (Street and Number or ghview Aven		ber, City o	r Town, State, 2	
the same of the sa	H	20a. Method of Disposition 1 © Burial 2 □ Cremation 3 □ Re	20b. F	Place of Dispo	sition (Na	me of	Date		ocation - City or	
DESILITIONE, MESTYLE PERMIT PAGES 1 and 2 should Depertment of Health and Men important: if them 27 is marke any injury or other traumatic once.		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Par		. Name a	tery 5-4 nd Address of Facility hn Funeral Belair Kd.	9~2005 dome			Maryland
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat	h. Do not ent	er the mo	de of dying, such as card	iac or respiratory			Approximate Interval Between Onset and Death
ate be executed hysicien and he buriat-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)							
box og sath certific attending pl tor use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3]Ectopic (oregnancy pecify)			23d. Date of del Month	ivery Day Year
vequires that the deben signed by the should be detached	b	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause given in Part I.		tobacco u		the cause of death?
	Completed							opsy formed?	24b. Were au prior to death?	stopsy findings available completion of cause of 2 No
ling Phys	ation; To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 1 Anner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other	Home 5 Res 28d. Describe	sidence (city) SCENE
or Attend atter death Director: /	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, facto	y, office		(Street and own, State		iral Route Number,
LIVI: To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2X Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death	h occurre vestigatio	f at the time, date and pla n, in my opinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	W. 1/2			c. License number OCME		MAY	4, 2005	5
	And the same of th	30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Type,	Print) 111	Penn Stree	t Balti	more,	Maryla	and 21201
S: Regis	tate trar	31. Date filed (Month, Day, Year) MAY 1 1 200	32. Ragistrar's Signa	ature	- 40					

		1 = For State Registrar		Marylan	-	artment tificate			ind Me	ental F	lygier	4 U U	5	159	10
Physicia	an	1. Decedent's Name (First, Middle, La Joseph C. Pod								2. Date of Month	1	0ay 005	Year	3. Time o	
/Medic Examin		4a. Facility Name (If not institution, gir		nber)		4b. City,	Town, or	Location of		lay		4c. County	of Death	12:05	am"
Examin	iei	Southern Mary				Cli						Princ	e Geo	orges	
Funeral		5. Social Security Number 6.		7. Age (In yrs. I 87	ast birthday) Yrs.	If Under Months		If Under 2 Hours		B. Date of Month,	Birth		9. Birthp	olace (State ontry)	or Foreign
Director		506-18-6026 Usual Residence of Decedent			TIS.				116	ii Cii	11,	1910	Nebi	raska	
yland		10a. State 10b. County		10c. City	, Town or Lo	cation							1	10d. Inside C	ity Limits
e Mar Sa-f si	ctor	MD Prince	Georges	Temp	ole Hil	lls								1 🗌 Yes	2.0¥No
with th	Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of V	Vhat Cour	ntry?	
eath y	Funeral	4204 Lyons Stre		dent Ever in U.	S. 13. V)748 ent of His	spanic Orig	in? (Spec	ify Yes or	U.S		e - Americ	can Indian,	
ione; Interlylating ZIZIS-U000 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural; or items 23a or 28a-1 show or other traumatic event, the Medical Evantian must be notified a	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For	ces? 2□No8/28 ates: 1/27	5/41	f Yes, spec		spanic Orig n, Mexican, Specify:	Puerto R	ican, etc.)		Blac	k, White, ::Whit	etc.	
72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usua kind of wor	l Occupa k done di	ution Juring most	of working	q	16b.	Kind of Bu	ısiness/Inc	dustry	
within ne.	idm	Elementary/Secondary (0-12)	College (1	-4or 5+)							110	777.4			
filed v Hygie other i		17. Father's Name (First, Middle, Las	, 6—		Agric	urtur		Econor 18. Mother		(First, Mid		SDA en Sumam	10)		
lid be lental rked o	To Be	James Podany						A	Anna	Svit	ak				
2 shou and N is mai	-	19a. Informant's Name/Relationship				-		nd Number	r or Rural	Route Nu	mber, Cit				
and and and math		Anna Podany / W	ife	COL D	4			reet,		-					
Dallinore, permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other		20a. Method of Disposition 1 ∰gurial 2 ☐ Cremation 3 [State Mon	lace of Dispo emetery, cren	natory or ot	her place	May 1:	3,200	55		Location -			
Dallino		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Ligg 	**	Mai	yland					_	Che	lter	nan M	aryla	ud
permit. Departmitimporta		Menta D.	Silder	maz8	4 00	3 016	۸٦,	s of Facility	Lee	Fune:	ral l	lome		MD 20	0725
200		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that ca	aused the death									INCOM	Approximation Interval Bet	te tween
Physician		Immediate Cause (Final disease or condition		CAN	asm.	x 1	fera	J F	Frank	VIVE				Onset and	Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	ue ce of):			•							
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):										
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
o / oU, ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):										
ate be ex ohysician the burial	dical	,	d												
BUX 00100, eath certificate be executed attending physician and for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ncy							23d Dat	e of delive	an/	
that the death cer ed by the attendir detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nth 2 ☐ Fetal ant at time of de		Ectopic pre Other (spe					_	Mor			Year
d by the detach		9 Unknown Part II. Other significant conditions			ulting in the un	adorh ing or	uso ano	n in Part I		23a D	id tobaco	n use contr	ibute to th	ne cause of o	death?
w requires that should be det	ed by	Tanin. Other significant conditions			atting at the di	idenying co	tuso give	er in Francis						ably 4 🗆	
The Coulds, T.C. BOX of The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as	Completed	1								24a. W	itopsy erformed	1 0	rior to cor leath?	psy findings mpletion of c	available ause of
rician: Ticlan: iclan: Ticlan: Ticlan: Ticlan: Ticlan: Ticlan: Ticlan: Ticlan:	0	25. Was case referred to medical						26. Place	of Death (NO 1	☐ Yes	2□ No	
Physiclan: Physiclan: ribis certific ral director,	To B	examiner? 1 🗆 Yes 2 🔼 No	and the second second		ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 🗆 Nur:	sing Home	e 5□R	esidence	6 🗌 Othe	er (<i>Specif</i>)	y)	
ding Physician: The lav ding Physician: The lav h. Atter this certificate has funeral director, page 2	lon:	27. Manner of Death 1 Natural 5 Pending		of Injury h, Day Year)	28b. Time of Injury	28 M	Bc. Injury Work	at ? ′es 2 □ N		3d. Descri	oe how in	jury occurr	ed		
l or Attending after death. Director: Attel in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not 1	000 01000	of Injury - At ho	me, farm, str			85 Z _ IV		3f. Locatio	n (Street	and Numbe	er or Rura	l Route Num	iber.
tal or /	Certification:	4 Homicide	buildir	ig, etc. (Specify	')					City or	Town, Sta	ite)			
DIVISION Othe Hospital or Attending within 24 hours after death othe Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying P 2 Medical Exe	hysicien: To the miner: On the ba and mann	sis of examinat	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	d place, an h occurred	nd due to t d at the tin	he cause ne, date a	(s) and ma nd place, a	nner as st and due to	ated. the cause(s	i)
Veithi 1 of 1	Σ	29b. Signature and title of certifier				290.	License	number 1431			29d. [ate signed	(Month,	Day, Year)	
41		Frank Sallyn	completed cause	^	23a) (Type,		RS	#10	77	T. W.	nhn	ghi	M	207	44
Sta Registr		31. Date filed (Month, Day, Year)	1 2005 b	egister's Signal	ture J.	Span	le le								

## Control Con				1 - For State of Maryland / Dep	artment of Health and Menta ertificate of Death	
S. Soud Security Number C. Sax A.		/Medi	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May, 8, 2005 4:15A
Part Part		Director		215-74-2008 1□M 2万F 46 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. (Min.	Month, Day, Year) Country)
Part Part		with the Maryland 3a or 28e-f show	i Director	MD Baltimore City Baltimore 10e. Street and Number	e 10f. Zip Code	
Secondary (0-12) College (1-4or 5-) Factory Worker 18 Mothers Name (First, Modes, Marchen Somerne) 18 Mothers Name (First, Modes) 18 Mothers Name (First, Mode	9500	hours after death tural', or Itams 2:		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 → No	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	(es or No., etc.) 14. Race - American Indian, Black, White, etc. Specify:
20a. Merbod of Disposition 1.5 Search 1.5 Service Serv	.cızız bu	a filed within if Hygiene. other then '		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 12 17. Father's Name (First, Middle, Last)	kind of work done during most of working DO NOT use retired) Dry Worker	fabric
Physician Phys	Maryia		To E	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Maili	ng Address (Street and Number or Rural Route	te Number, City or Town, State, Zip Code)
Physician Medical Examiner Physician Medical Examiner Physician Ph	je,			20a. Method of Disposition 1. Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn	sition (Name of Date natory or other place) Cemetery 2005	20c. Location - City or Town, State
Due to (or as a consequence of): d. FEMALE 23d. Date of delivery 23d.	ļ	Physician /Medical	9r	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	717 Green Pastures Driv	ve Baltimore Maryland 212
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Wasner of Death 1 Notural 1 Noture 1 Note 1 Noture 1 Note 1 Noture 1 Note 1 Noture 1 Noture 1 Note 1 Note 1 Noture 1 Note 1 Noture 1 Note 1 Noture 1 Noture 1 Noture 1 Noture 1 Note 1 Notur	,	armicate ba executed ing physician and e as the burial-transit	Ilcai	resulting in death) Last C. Due to (or as a consequence of): d.		
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25. Was case referred to medical syaminer? 1		een signed bould be det	ted by P		iderlying cause given in Part I. 236	Be. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐Unknown
Second S	The land	ifficate has b	a	25. Was case referred to medical	10	autopsy performed? prior to completion of cause of death? Yes 2 № No 1 □ Yes 2 □ No
29a. Certifier (Check only one) 29b. Signature and; title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and; title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ioional paine	After this	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Hospital: 1 Inpatient 2 ER/Outpatient 2 ER/Ou	Other: 4 Nursing Home 5 28c. Injury at Work?	Residence 6 Other (Specify)
Helical Hruse officer D45148 May 8, 2005 The arms and address person who completed course of death (Item 23) (Type, Print) PICARTO 1. OSURNO, HON Secours Hospital, 2000 West Bultimore, Bultimore, Mayland, 20	onital or Att	nours after d		4 Homicide determined 299. Place of Injury - At nome, farm, stre building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	City	y or Town, State)
31 Jame Ind addre & person who completed cause of death (Item 23) (Type, Print) LICARTO 1. OSURNO, BON SECOUTS HOSPITZI, 2000 WEST BUSTIMOTE BUSTIMOTE, Bustimore, Maryland, 20	To the Hoe	within 24 h To the Fur completely		29b. Signature and title of certifier	29c. License number	e time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
State 31. Date filed (Month) Day, Year) 32. Registrar's Signature	3	1		ame nd addre person who completed cause of death (Item 23) (Type, FICALLY) . OSURNO . DEM SECOUS (100 ptz) 31. Date filed (Month, Day, Year) MAY 1 1 2005	(2000 West Bultimore 5	Treet, Bultimore, Hayland, 2122

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			1 - For State Registrar	State of M	larylan		artmen rtificate				lental H	ygien Reg. N	200	pia.	150	112
	Physic	ian	1. Decedent's Name (First, Middle, La	UCHA				· ·			2. Date of D	Death		Year	3. Time	of Death
	/Medi Exami	cal	FRANK PR 4a. Facility Name (If not institution, give)		4h Cih	Tour	Location	-4 D4b	WHY	08	S 20	005	11:15	Ам
1	LXaiii	ici	. 1	1	ente	_	RA	nda	15 to		no -26	0	0 1		ore	
	Funeral		5. Social Security Number 6. S		ge (In yrs. 1.	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, C Februar	irth Day, Yea	r)		place (State	o <i>r Foreig</i> n
	Director		220-24-6035 Usual Residence of Decedent		101	Yrs.					Februar	y 11,	, 1904	Mary	/Tánd	
	larylan show	2	Maryland Baltir	mre		, Town or Lo							-	1	0d. Inside (
	the M 28a-f	recto	10e. Street and Number		I NC			0-4-								s 2 X No
	th with	Funeral Director	314 Sacred Heart Lane	<u>;</u>			10f. Zip	211	.36			10g. C	itizen of W USA	hat Cour	itry?	
	ter dea	uner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race	- Americ	an Indian,	
920	ours after death with the Maryla rel', or Items 23a or 28a-f shov Examinar must be mailifed at	by	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates.	No		1 ☐ Yes 2		Specify:	,	, , ,		Specify:			
2-0	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show the Madical Examiner must be notified at	Completed	15. Decedent's E. (Specify only highest gra	ducation		16a. Deced	dent's Usua	I Occupa	ition	t of worki		16b. I	Kind of Bus			
121	d within 72 ho piene. r then "netur Ibe Madical	ldmo	Elementary/Secondary (0-12)	College (1-4or	5+)	Postal	kind of work)	t di worki	ng					
d 2	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last,			rustai	Super		18. Mothe	r's Name	(First, Middle		ost Of			
ylar		ToE	Frank Prucha							' Svec				,		
Maryland 21215-0036	an an		19a. Informant's Name/Relationship (Janet Connelly/Daugh			19b. Mailin					I Route Numb				Code)	
re,	ges 1 and 2 it of Health If item 27 or other tree		20a. Method of Disposition		20b. Pla	ace of Dispos	sition /Nam	e of			erstown Pate	_	land 2	21136 lity or To	wn. State	
Baltimore,	Pages ment of I ent: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	v)	Park	metery, crem KWOOd Ce			·	5/13/	05		timore	-		
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer	L. Hil	ton 22	Name and	Address	s of Facility	y Inc	1115			11000	una		
			23a. Part1. Enter the disease, or com	Bal-	timore M	ary la	ind 21	214	Approxima	to.						
	Physician	80	shock, or heart failure. List only Immediate Cause (Final disease or condition	a. CONGES	IIG.				LUR		, roopilatory t	x1165t,			Interval Bet Onset and	tween
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):										
	90	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated awarts.	Due to (or as			21231	,								
V	cuted nd ransit	Examiner	triat mitiatad avents	c	·											
8760,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as	a conseque	ence of):										
687	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edlcal		d										-		
XOX	that the death certificed by the attending problems detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth	of pregnance		Ectopic pre						23d. Date of	of deliver	у	
P.O. Box	he dea the at	ysicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown			Other (spec						Month	1	Day '	Year
۳,	res that this igned by be detact	by Ph	Part II. Other significant conditions co	ontributing to death bu	ut not result	ing in the un	derlying cau	usa giver	in Part I.		23e. Did t	obacco	use contribi	ute to the	cause of d	leath?
Vital Records,	w require been sig should b		437 3700 A	AL FP	411-10	RE					10	Yes 2	□No 3	☐ Proba	bly 4	fnknown
Sec Sec	e law n has be e 2 sh	Completed	MYOCARDIAL	INFARE	11011						24a. Was	osy	24b. We	re autop	sy findings a	available
		e Col	25. Was case referred to medical								perfo	rmed? 2 No	dea	ith?	!□ No	
<u> </u>	Physicie this cert al direct	To Be	examiner?	Hospital: Impatie	nt 2 Ef	P/Outpatient	3□ DOA	Other			(Check only only only only only only only only		6 □Other	(Spanify)		
Division of	ding Ph After th funeral		27. Manner of Death	28a. Date of Injur (Month, Day	v 2	8b. Time of Injury		2. Injury a Work?	at		Bd. Describe					
isio	death death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	Inv. At hom	e farm stro	M factors of		s 2⊡N		D4 14' //	24				
2	s after s after al Dire ad in b	Certification:	4 Homicide determined	building, etc	. (Specify)	o, iaim, suee	er, ractory, c	onice		20	Bf. Location (S City or Tox	vn, State	a Number (or Rurai	Route Numi	ber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director. After this certificacompletely filled in by the funeral director,	edical (29a. Certifier 12 Certifying Phy (Check only 2 Medical Exem	rsician: To the best of		edge, death on and/or inve	occurred at	the time	, date and	place, ar	nd due to the	cause(s)	and manne	er as sta	ted.	
	o the vithin 2 o the omplei		one) 29b. Signature and the of certifier	and manner sta	ted.			License r					e signed (A			
	- 5 - 0		1 Jonn				7	-	1783			MA			Qo	05
	16		30. Name and address of person who c	ompleted cause of de	eath (Item 2 IHAR	3a) (Type, P	rint)	540	1 0	LD	COUR	T	PO AS	1120		
24	5 Sta	e	AVVERALAND 31. Date filed (Month, Day, Year)	32. Registra				KAN	DAL	251	N 600		WD 3	1103		
	Registra		MA	Y 1 1 2005	190		k /	Cont	0 2							

				State of			artment of			-	_	ible.	17010
		1	For State Registrar			•	rtificate o				eg. No.	15	15913
Dhoo	aiaia		1. Decedent's Name (First, Middle,	Last)					2	2. Date of Deat Month	h Day	Year	3. Time of Death
Phys /Me	edica	al -	Ann C. Powers				1			May 6,	7		10:30 P M
Exa	mine	er	4a. Facility Name (If not institution,		iber)		4b. City, Town		of Death			ty of Death	
Funo	rol		Carriage Hill- 5. Social Security Number		7. Age (In yrs	. last birthday)	Bethes	ar If Under		B. Date of Birth		gomer 9. Birthr	place (State or Foreign ntry)
Fune Direct			201-14-1171	1□M 2뮻F	81	Yrs.	Months Day	rs Hours	Min.	(Month, Day, oct. 29,	Year) 1923		sylvania
p s			Usual Residence of Decedent 10a, State 10b, County		100.0	ity, Town or Lo	vestion						10d. Inside City Limits
Aaryla Fshor			Maryland Montgo	nery		thesda	oution .						1 ☐ Yes 2% No
the N		rect	10e. Street and Number				10f. Zip Code	9		1	0g. Citizen of	What Cou	ntry?
death with the Maryland ms 23a or 28e-f show		Funeral Director	5225 Pooks Hill	Road, #53	L3N		20	814			United	Stat	es
r deat		iner	11. Marital Status	12. Was Deced	dent Ever in	U.S. 13.	Was Decedent of	f Hispanic Ori	igin? (Speci	ify Yes or No- ican, etc.)		ace - Americack, White,	
s afte		by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes :	2 ⊊ No		1 □ Yes 25 N				Spec	ifu:	
hours af	1	ed b	3X Widowed 4 □ Divorced 15. Decedent's	Year or Da	tes:	16a, Dece	dent's Usual Occ	upation			16b. Kind of I		nite
Medic		ompleted	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	40r 5+\	(Give	kind of work dor DO NOT use reti	ne during mos ired)	st of working	y i			County
A with		CO .	Elementary/Secondary (0-12/	5+		Teac	her	,			Public	Scho	ols
IZITIO td be file ental Hy ked oth		e	17. Father's Name (First, Middle, L	•						(First, Middle, N	Maiden Suma	me)	
DalitimOre, INIATyTATIO ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 22 15 marked other than "netural", or Items 23a or 28e-1 show any Injury or other fraumatic ayant. If Medical Extra Herring to a refitted.		۵.	Paul R. Crawford			100 11 11				lligan			0.41
Mal d2st d2st thanc T1sn traun			19a. Informant's Name/Relationsh Sharon P. Sivert		nter	1	ng Address <i>(Stre</i> Foxhall						DC 20007
Heal Heal		-	20a. Method of Disposition	.seli, baasi	20b.	Place of Dispo	sition /Name of		Da	te	20c. Location	- City or To	own, State
Pages ent of nt: If i			1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Sp		State	ate of Cemet	Heaven	nace) i	May 13 -2005	3,	Silver Maryla		.ng,
Dallinor Dermit. Pages Department of mportant: If it	OUCE.		21. Signature of Funeral Septice L	- A		22	Name and Add	dress of Facilit	Nkoher	rt A. P	umphre	v Fun	neral Home/
	8		MAS /J	1	00689	ье	tnesda- Bet	hesda,	Chase Mary	land 20	814-35	Wisco	onsin Avenue
			23a Parti Enter the disease, or can failure. List of	omplications that ca nly one cause on ea	used the dea ich line.	ath. Do not ent	er the mode of d	lying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
Physici	_	1	Imm te Cause (Final disease or condition resulting in death)	_ aŦ	114	ORZ	70	145	210	ع		1	Oriset and Death
/Medic Examin			resulting in death)	Due to (d	or as a conse		~ ^						
¢.		e	Sequentially list conditions, it any, loading to immediate cause. Enter Underlying	b. Due to (r	ir as a conse	dinautoring).	\$5						
uted		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	4	550	127	sien						
ou, be executed ician and burial-transit			resulting in death) Last	Due to (c	or as a conse	quence of):							
S S S		lca	1	d									
death certifical death certifical eattending phyddon to be as the	3	/Med	IF FEMALE:	23c. If yes, outc	come of pregr	nancy					224 5	-44-15-	
Both c atten		Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bir	rth 2 ☐ Fei ant at time of	tal death 3	Ectopic pregnar Other (specify)				1	ate of delive lonth	Day Year
the d		hys	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unkno			(/ /						
requires that the seen signed by the hould be detached		by P	Part II. Other significant condition	s contributing to de	ath but not re	sulting in the u	nderlying cause	given in Part I	l.	23e. Did tob	acco use cor	ntribute to the	the cause of death?
taw requires as been sign										1 TYe	s 2 No	3 Prob	bably 4 □Unknown
taw ri	5 .	ompleted								24a. Was ar autops	v	prior to co	opsy findings available ompletion of cause of
The The cate had	2	Cod								perform 1 Yes 2		death?	2 No
Off Off Vital Recoding Physician: The law In. After this certificate has the fundral director page 2 s		Be	25. Was case referred to medical examiner?	Hospital:			- (Mac		Check only on			_
Phy Play	2	2	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of	11 3 DOX	347140		e 5 🗌 Reside 3d. Describe ho			5/)
Attending r death. Sector: After by the fune		ertiflcation;	1 Natural 5 Pending 2 Accident investig		n, Day Year)	Injury	W	∛ork? ∐Yes 2∐	No				
VISIO Attendi er death. actor: A by the fu		iil	3 Suicide 6 Could not determine	and 259. Place	of Injury - At I	home, farm, str	reet, factory, offic	:e	28	of. Location (St. City or Town		ber or Rura	al Route Number,
ital or Safte		Cer		Julian							, 0.0.0)		
To the Hospital or Attend Within 24 hours after death To tha Funaral Director:	in high	edical	(Check only 2 Medical E	Physician: To the l xaminer: On the ba	sis of examin	nowledge, death nation and/or in	h occurred at the vestigation, in my	time, date an y opinion, dea	nd place, an ath occurred	nd due to the ca I at the time, da	ause(s) and mate and place	nanner as s , and due to	itated. o the cause(s)
thin 2 than 2 than		Sec	one) 29b. Signature and title acertifier	and mann	er stated.		29c. Lice	nse number		25	9d. Date sign	ed (Month.	Day, Year)
F 3 F 8	~		λ.	// V.	\			0051	200		_	_	L005
107			30. Name and address of person w	no completed cause	of deal (Ite	em 23a) (Type.		١٠٠٠			0 -	1-3	
U		ä	Anushiravan Dad	gar, D.O.	, 971	.5 Medi	cal Cent		ive #2	201, Roc	kville	, MD	20850
1910	Stat		31. Date filed (Month, Day, Year)	32. Re	gistrar Sign	nature	Speed	2					
Reg	jistra	ır	MA MA	Y 1 1 200	pull	יית ניצו	7						

		·	1 - State Registrar	•	epartment of Health and Certificate of Death	Mental Hygie	2005 15011
	Physici		Decedent's Name (First, Middle, Last)	lbert L. Philbric	k	2. Date of Death	Day H 2005 3. Time of Death
	/Medio Examir		4a. Fability Namo (14 not institution, give street	and number)	4b. City, Jown, or Location of De	ath (a	4c. County of Death [County of Death
	Funeral Director		5. Social Security Number 6. Sex 201.10.4087 1 X M 2	7. Age (In yrs. last birth)	Months Davs Hours M		
	f show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o		July 19, 18	Massachusetts 10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the A 3a or 28a-	i Director	Maryland Howard 10e. Street and Number 10097 Century Drive		Ellicott City 10f. Zip Code 21042		Citizen of What Country?
98	172 hours after death with the Maryland "natural", or Itams 23a or 28a-f show salesa Experimer must be notified at	y Funerai	11. Marital Status 12. WAR 1 Never Married 2 Married 1 If	as Decedent Ever in U.S. med Forces? Yes 2 \(\sum \) No 76s, Give 1941	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc.
21215-0036	72 na	Completed by	3 Widowed 4 Divorced Yes 15. Decedent's Education (Specify only highest grade com.	nar or Dates: 1944 16a. D	ecedent's Usual Occupation Give kind of work done during most of v fe. DO NOT use retired)	vorking 16b	. Kind of Business/Industry
	e filac of hay vent,	Be Com	Elementary/Secondary (0-12) Co. 12 17. Father's Name (First, Middle, Last)	llege (1-4or 5+)	Machinist 18. Mother's N	ame (First, Middle, Maid	Donut Corp. of America
Maryland	2 should and Men is marka sumatic	ToE	Harold L. Phi 19a. Informant's Name/Relationship (<i>Type, Pr</i>		failing Address (Street and Number or	Rural Route Number, Ci	
altimore, N	as 1 an of Heal fitam 2 rothar		Ms. Terry Green 20a. Method of Disposition 1 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	al from State cemetery,	495 Cardinal Drive Lusby isposition (Name of crematory or other place)		7 . Location - City or Town, State Garrison Forest, Maryland
Balti	parmit. Pag Department Important: I any injury o		21. Signature of Funeral Service Livensee	Maria (Sel	22. Name and Address of Facility Slack Funeral Hol	me, P.A.	17.00
	Physician /Medical		23a. Part1. Enter the disease, or complication hock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do not se on each line. SEPS Due to (or as a consequence of)	15		Osset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of)	E GANGREN	005 TO1	6-8 West
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events c c	Due to (or as a consequence of)	TES 160	07	> 10 year
.O. Box 68	The law requires that the death certifics to has been signed by the attending ploage 2 should be detached for use as I	Physician/Med	in the past 12 months?	ves, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Δ.	quires that in signad by uld be deta	by	Part II. Other significant conditions contributions	ng to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobaco 1 ☐ Yes	co use contribute to the cause of death?
al Records,	10	Completed				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital	Physic this ce al direc	To Be	25. Was case referred to medical examiner? □ Yes 2 No Hospita 27. Manner Death 288	Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 Residence 28d. Describe how in	
Division	uttanding death. ctor: After / the funer	Certification;	Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,
۵	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	edical Ceri	29a. Certifier Certifying Physician (Check only 2 Medical Examiner: O	To the best of my knowledge, o	eath occurred at the time, date and pla or investigation, in my opinion, death oc	ce, and due to the cause	e(s) and manner as stated.
)	To the within 2 To the comple	Med	29b. Signature and title of certifier	Piname states.	29c. License number	7)	Date signed (Month, Day, Year) 1AY 4+4, 2005
(6.7		30. Name and address of person who complete Barahona, Leonal MD 1101	-			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 1 2005	22 Pagietrarie Cignatura			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dav Zivile Reikenis May 9 2005 1:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14219 Phoenix Road Phoenix Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M aXXF Director 174-26-2446 79 7, 1925 Lithuania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show any niury or other treumetic event. If a Modical Examiner must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Phoenix 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14219 Phoenix Road Completed by Funeral 21131 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Homew 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vytautas Mykolaitis Anele Biskis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Reikenis/husband 14219 Phoenix Road, Phoenix, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/13^D/2005 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | Cemetery, crematory or other place) US/
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens Timonium, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer Physician Met astatic /Medical Due to (or as a consequence of): **Examiner** Lymphoma Sequentially list conditions, Examiner if any, leading to initial actions actions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? 2 2 No Completed 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 ▼ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA Scott Adam Road MA 54 JUHE SIMUH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 1 2005

		1 - For State Registrar	State	of Maryland		artment of H rtificate of	Health and N Death	1ental Hy	giene Reg. No.	JUJ	13910
Dhusia		1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
Physic /Medi		Carrie Elizabet	h Rauscl	ner				Month	05	2005	1:00am ^M
Examir		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Town, o	or Location of Death		4c.	County of Deat	
		Calvert Manor				Rising S				Cecil	
Funeral Director		5. Social Security Number 220-22-0487 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07 / 13 /	th 1914	(00	nplace (State or Foreign untry) "yland
death with the Maryland ms 23a or 28e-f show		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
ier death with the Marylan Items 23a or 28e-f show	to	MD Harfo	ord	Нал	re d	e Grace					1XYes 2□No
r 28e	Director	10e. Street and Number	л <u>а</u>	110	vie u	10f. Zip Code		1	10a. Citiz	en of What Co	
th wit	a D	505 Congress A	venue.	Apt. 401		21078			USA		, .
	Funeral	11. Marital Status	12 Was Dec	edent Ever in II S		Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No		4. Race - Amer	
s afte	y Fu	1 Never Married 2 Marrie	Armed F	2 XNo	1	i res, specify Cuba I⊡ Yes 2 X No	an, Mexican, Puerto Specify:	Hican, etc.)		Black, White	, etc.
hours ural;	d by	3 X Widowed 4 □ Divorced	Year or [Specify: W	nite
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other treumatic event, the Medical Exam ones.	Completed	15. Decedent's (Specify only highest	s Education grade completed)		(GiVe	lent's Usual Occup kind of work done DO NDT use retired	during most of work.	ing	16b. Kin	d of Business/I	ndustry
with iene than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	<u>a)</u>		Ша		
e filec I Hyg other	BeC	17. Father's Name (First, Middle, L.	ast)		11011	ielliakei	18. Mother's Name	(First, Middle.		me Sumame)	
uld be Menta rked ric ev	To B	Ernest Gibson					Mary H				
shot and N		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailin	g Address (Street	and Number or Rura		er, City or	Town, State, Zi	p Code)
and 2 salth n 27 i		Carrie R. Adams	s- Niece				., Havre				
of He		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	2 Domount from	20b. Plac	ce of Dispo	sition (Name of natory or other place	Г	ate		ation - City or T	
Pag ment ant: I	1 2	`4 □ Donation 5 □ Other (Spe	ecify)	State		is & Co.	,	/05 \	Nest	Cheste	r. PA
permit Depart Import any in		21. Signature of Funeral Service Li	censee	4.0					00 E	Δ	
₫ □ <u>=</u> = a		squame 1	m, ∞	net) 12	3 S. Was	ss of Facility nith Fune shington,	Havre o	de G	race, M	D 21078
		29a: Part1. Enter the disease, or c shock, or heart failure. List or	omplications that only one cause on a	caused the death. each line.	Do not ente	er the mode of dyin	ig, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between
Physician	G - V	Immediate Cause (Final disease or condition	, F	deute:	Mus	scardia	1 Inta	tion			Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conseque		^	0.	CC UN	γ.		10
	_	Sequentially list conditions,	b	ORDNA	RY	METEN	20 Dis	acre			Joans
ocuted nd transit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due (o	(or as a consequer	nce of):						
and al-tra	Exar	that initiated events resulting in death) Last	c	(or as a consequer	nce of):						
siciar siciar buri				,	,						
ificat g phy as the	edic		O								
es that the death certificate be exe igned by the attending physician at be detached for use as the burial-t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnanc					23	3d. Date of deliv	an.
deatle e atte	icla	in the past 12 months?	4☐Pregn	oirth 2 🗌 Fetal de lant at time of deat		Ectopic pregnancy Other (specify)			1	Month	Day Year
by the	hys	9 Unknown	9∐ Unkn						!		
gned be de	by F	Part II. Other significant condition:	s contributing to de	eath but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use	e contribute to t	he cause of death?
w require been sig	ted	Dementica	of I	Alzhein	meis	lype	,	1□Y	es 2	oNo 3□Prob	pably 4 Unknown
law re as be 2 sho	ple					1.		24a. Was a		24b. Were auto	psy findings available
ician: The law requires that the death certificate be executed sertificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit	Completed	-						autop: perfor	med?	prior to co death?	mpletion of cause of
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Death		2 (No	1 🗌 Yes	2 LJ 140
			Hospital:								

Baltimore, Maryland 21215-0036

Be Completed by Phy

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification; To

Hospital:

1 [] Inpatient

28a. Date of Injury (Month, Day Year)

3 DOA

26. Place of De	ath (Cl	neck only one)		
r: 4 ursing	Home	5 Residence	6 □Other	(Specify)

Other: 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

0058354

29d. Date signed (Month, Day, Year)

30. Name and address of person

31. Date filed (Month, Day, Year) 32. Re Grar's Signature

State Registrar

10

To the Funerel Director: After this certific completely filled in by the funeral director,

within 24 hours after death. To the Funerel Director: A

MAY 1 1 2005

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide



2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

			1 - For State Registrar		of Maryland			t of H	lealth a				2005	15917
	Physic	ian	Decedent's Name (First, Mid	dle, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi		Douglas		Frederi	ck		R	obins	son	May	7	2005	7:30 a ^M
7	Exami	ner	4a. Facility Name (If not instituti 1514 Riverda		u <i>mber)</i>				Location o	of Death		4c.	County of Deat	h
					T=		-	napo					Anne A	
	Funeral Director		5. Social Security Number 367-30-3432 Usual Residence of Decedent	6. Sex XXM 2□ F	7. Age (In yrs. Ia	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day July 14	, Year) 19:	9. Birtl Co 34 Micl	hplace (State or Foreign untry) higan
	/land		10a. State 10b. Coun	ty	10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Man H sh	ţō	MD Anne	Arunde1	An	napo1	is							1 ☐ Yes 2X No
	r 28c	Funeral Director	10e. Street and Number				10f. Zip	Code			1	l0g. Citi:	zen of What Co	untry?
	th wit	aiD	1514 Riverda	le Drive				2140	1				USA	
	dea dea	ner	11. Marital Status	12. Was De Armed F	cedent Ever in U.S	S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	1	14. Race - Ame	
98	or its	Fu	1 ☐ Never Married 2 🛣 Ma	rried 1 TYes	2X XNo		1 ☐ Yes		Specify:	, rueno	rican, etc.)		Black, White	
8	hours ural',	d by	3 Widowed 4 Divorce		Dates:								Specify: V	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. tther than "natural", or itams 23a or 28e-f show inth, the Medical Everting must be notified at	Completed	15. Decede (Specify only high	ent's Education est grade completed)	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>(uring</i> most	of worki	ng	16b. Kir	nd of Business/l	Industry
12	withii ene. than	mc	Elementary/Secondary (0-12)	College	(1-4or 5+)				,					
d 2	should be filed within and Mental Hygiene. is markad other than aumatic event, ILA MA		17. Father's Name (First, Middle	, Last)		Ful	chasi	ng	18. Mother	r's Name	(First, Middle, i		Comotive Sumame)	2
lan	id be ental kad o	To Be	Frederick Rol	ninson							onstable		oumamo,	
Maryland	should nd Men marka umatic	 	19a. Informant's Name/Relation			19b. Mailir	ng Address	(Street a	Ann		I Route Number		Town State 7	in Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. itam 27 is markad other than "natural", or itams 23a or 28e-f show other traumatic event, the Medical Eventiner must be notified at		Barbara G. Ro	obingon (W	life)						Annapol			
re,	es 1 and 2 of Health f itam 27 i	11	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nam	ne of		VC,			cation - City or	
Ē	Pages nent of It ant: If its		1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (1 State	ro Cr				-9-20	005	Ralt	imore,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeyal Service	e Licensee	//		2. Name and	d Addres	s of Facility	7			, Limo Le ,	TID .
<u> </u>	8 G E 8 9	14	Datack	of alest	1		_12 R:	idge	lv Av	enue	Home, P	olis	. MD 21	401
			23a. Part1. Enter the disease. c shock, or heart failure. Lis	or complications that st only one cause on	caused the death. each line.	Do not ent	er the mode	e of dying	, such as c	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a		Em	physe	ema						Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseque		11							
		L .	Sequentially list conditions,	b. — Due to	(or as a conseque	200 00:								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseque	erice or):								
	al-tra	хаг	that initiated events resulting in death) Last	c	(or as a conseque	ence of):								
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	cal												
9	g physias the	ba		0.										
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnand		3e					23	3d. Date of deliv	very
-	the attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 Fetal d mant at time of dea		Ectopic pre Other (spe						Month	Day Year
P.0	≠ > 2	hy	9 Unknown											
Ś	se du ec	by 6	Part II. Other significant condit	ions contributing to d	death but not result	ing in the ur	nderlying ca	use give	n in Part I.					the cause of death?
ord	w require been si should b	ted									1 25 Ye	s 2 🗆	No 3 ☐ Pro	bably 4 Unknown
Vital Record	law 2 st	Completed									24a. Was ar autops		24b. Were auto	opsy findings available ompletion of cause of
H H	Th ate pag	Cor									perform 1 ☐ Yes 2	ned?	death?	2 🗆 No
Žį.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitals				Other			(Check only one			
o	Phys r this ral dir	- To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 El	R/Outpatien 8b. Time of		_	4 Nurs		ne 5 Reside			fy)
Division of	Attanding F r death. actor: After by the funer	ertification;	1 Natural 5 Pendi		nth, Day Year)	Injury	M	Bc. Injury Work'	at es 2⊡N		8d. Describe ho	winjury	occurred	
/ISI	f or Attandi after death. Diractor: A in by the fu	fica	3 Suicide 6 □ Could	not be	e of Injury - At hom	e, farm, stre					8f. Location (Str	eet and	Number or Run	al Route Number.
Ö	alor A s after N Dirac	Cert	4 Homicide determ	build	ling, etc. (Specify)						City or Town	State)		
	e Hospital 24 hours a 8 Funarel i letely filled		29a. Certifier 1 Certifyi	ng Physician: To the	e best of my knowle	edge, death	occurred a	t the time	e, date and	place, a	nd due to the ca	use(s) a	and manner as s	stated.
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funarel Diractor: After th completely filled in by the funeral	edical	one)	CAMILLIAM. OIL ING D	ner stated.	n and/or inv	estigation, i	in my opi	nion, death	occurre	d at the time, da	ite and p	place, and due t	o the cause(s)
	To the within 2.	Σ	29b. Signature and title of certific	reid Ber	h. Mo		29c.	License	,		29	d. Date	signed (Month,	Day, Year)
•	10			J				4	16052				18/05	
10	7'		30. Name and eddress of person	3e h M	se of death (Item 2	(Type, F	erint)	Je,	#121	an	majoli)	, M	UD	
	Sta Registr	te ar	30. Name and oddress of person 31. Date filed (Month, Day, Year MAY 1 1	2005 See	Registrar's Signatur	Gosa	W							

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Dl		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medi		Meredith Louise Rul) May 2 205 0730 M
	Examir	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anapolis
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Number 8. Date of Birth 9. Birthplace (State or Foreign
	Director		N/A 1 M 2 F 8 Yrs. Months Days Hours Min. (Month, Day, Year) Usual Residence of Decedent
	ryland how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	he Ma	Director	1 me Hundel Annapolis 12 Yes 2 No
	Sa or 2		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10g. Citizen of What Country?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	72 hours after death with the Maryland natural', or tems 23a or 28a-f ahow deat Exe ciner mail be rediffed at	by Fu	Armed Forces? 1
21215-0036	72 hou natura lical E	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
121	within 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A A College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)
	filed v Hygie other t	e e	12-Father's Name (First, Middle, Last) 14: Mother's Name (First, Middle, Maiden Sumame)
/lan	should be and Mental marked o	To B	Rick Ruhf Glosa Elizabeth Day
Maryland	C	1	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R, ute Number, lity or Town, State, Zip Code)
	Health tem 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Twn, State
m _o	Pages nent of I ant: If its		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Metro Crematory 5/11/2005 Baltimore, MD
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Poneral Service Libense 22. Name and Address of Facility Hardesty Funeral Home, P.A.
	403 60		12 Ridgely Avenue, Annapolis, MD 21401
	Physician	ă ă	Interval Between Onset and Death Onset and Death
	/Medical Examiner		disease or condition resulting in death) a.
	Cxammer	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events c
, 0,	reate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	d
Вох	h certii ending use a	JW/W	IF FEMALE: 23b. Was decedent pregnant in the cast 13 months? 23c. If yes, outcome of pregnancy 1
о С	that the death certific ed by the attending p detached for use as	sicle	In the past 12 months? 1 Yes 2 10 On the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown
, P.O.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	w requires that been signed be should be det	ed b	Circhial Infarction 1 Tyes 200 No 3 Probably 4 Unknown
eco	e law re has bea je 2 sho	Completed by	Liver Failure 24a. Was an autopsy findings available prior to completion of cause of
a H	sicien: The certificate f rector, page		performed? death? 1□ Yes 1X No 1□ Yes 11 No
Division of Vital Records,	ysicientis certii	To Be	25. Was case referred to medical examiner? 1
0 0	ng Ph (fter th	L:uo	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?
<u>s</u>	death.	icat	2 Accident investigation 3 Suicide 6 Could not be adelemined determined. 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number.
<u>></u>	al or A s after il Direction by	Certification:	4 Homicide 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State).
	Hospit 4 hours funere	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Med	29b. Signature and fitte of certified 29c. License number 29d. Date signed (Month, Day, Year)
	- 5 - 0		
		1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta	6	31. Date filed (Mortur, Day, Tear) 32. Registrar's Signature
	Registr		MAY 1 1 2005
DHN	MH 17 Rev 1/20	01	ORIGINAL
			UNIGHNAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year mal 2005 Izabeth (Innot institution, give street and number) 4b. City, Town, or Location of Death County of Death enter Hrundel hedical If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex Birthplace (State or Foreign Country) Days 3 6 1□M 20 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No mi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 116 Hendree 2140 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (M) No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1, Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 17 Eather's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Ruh 9 112abeth a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muht 1110 McKendree 2140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2005 Baltimore, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final martur day resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or ripury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred

Physician /Medical Examiner the death certificate be executed

Examiner

Physician/Medical

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Completed

Be

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Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked o any injury or other treumatic eve

Maryland 21215-0036

Baltimore,

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Records,

Division of Vital

or Attending Physician:

To the

the Medical Examinary

Funeral Director

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the attending physicien and hed for use as the burial-transit signed by 99 peen page 2 this certificate After thi

To the nospection within 24 hours after death.

To the Funeral Director: After the funeral by th

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Yeer) 13

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 🗌 No

NIA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and Atle of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30 ame od address of person who completed cause of death (Item 23a) (Type, Print)

in HD

2005

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrats Signature

			For State Registrar		State of	Marylar		artmen <i>rtificat</i>				lental Hygi	ene g. No.	105	159	20
	Discostati		1. Decedent's Name (First, Middle	Last)								2. Date of Death Month	Day	Year	3. Time	of Death
	Physicia /Medic			(Guille	rmo Ru	ian					May	- '	2005	9:50	AM M
	Examin		4a. Facility Name (If not institution	give str	eet and num	nber)		4b. City,	Town, or	Location	of Death		4c. C	County of Dea	th	
			8837 Co					1411-7-	4.97	Poto					gomery	
	Funeral		5. Social Security Number	6. Sex 1█ N	4 2□F		. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day,			thplace (State	
	Director	ļ	219-31-0195 Usual Residence of Decedent			62						January 5	194	3	Colomb	oia
	/land		10a. State 10b. County			10c. C	ity, Town or Lo	ocation							10d. Inside	City Limits
	Man,	tor	Maryland Mon	tgon	nery					Potom	ac				1 🗆 Y	es 2 🛚 No
	th the	Directo	10e. Street and Number			•		10f. Zip				10	g. Citiz	en of What Co	ountry?	
	23a (8837 Co	Ld S	pring	Road				2085	54			Can	ada	
	r dea	Funeral	11. Marital Status		Armed For	dent Ever in t ces?	J.S. 13.	Was Deced	lent of Hi	ispanic Ori n, Mexicar	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)	14	 Race - Ame Black, White 		
2	s afte	by Fu	1 ☐ Never Married 2 🕅 Marri 3 ☐ Widowed 4 ☐ Divorced	ed	1 ☐ Yes If Yes, Give Year or Da	2 X) No		1 X Yes	2□ No	Specify:			5	Specify:		
3	hour turel		15. Decedent	's Educa		1162.	16a Dece	dent's Usua	al Occup	ation	Со	<u>lombian</u>	6h Kini	d of Business	Whit	e
2	n "ne	Completed	(Specify only highes		completed)	Acr E.	(Give	kind of wo DO NOT us	rk done d	lurina mos	t of work	ing	00111111	0. 500000		
7	d with jiene. r thau	E O	Elementary/Secondary (0-12)		College (1-			Civ	il E	ngine	eer			World	Bank	
2	e filed Il Hyg othe vent,	a u	17. Father's Name (First, Middle, I	ast)								(First, Middle, M	aiden S			
0	uld by Venta rrked ric ev	To B	Manı	iel A	Antoni	o Ruan	l .				M	Maria Hel	ena	Guerr	ero	
<u></u>	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-f show other traumatic event, the Medical Exertires must be notified at		19a. Informant's Name/Relationsh	nip <i>(Type</i>	, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Number,	City or	Town, State,	Zip Code)	
~	and salth n 27		Juan Carlos Rua	in/ !	Son		8837	Ço1d	Spr	ing R	load	Potomac.				
ב כ	of Har		20a. Method of Disposition 1 Burial 2 Cremation	3 □Rer	noval from S	State 20b.	Place of Dispo	nsition (Nar matory or o	ne of ther plac	θ)		Date 2	Oc. Loc	ation - City or	Town, State	
	Pag ment ant: ury c		`4 ☐ Donation 5 ☐ Other (Sp	ecify)		C	ontgome remator	rium :	Inc.	М	av 9	,2005_	Bet1	hesda,	Maryl	and
<u> </u>	perriit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 2005		21. Signature of Funeral Service I	icensee	_ /	,	R	2. Name an ockvi	d Addres 11e,	ss of Facili Inc .	ty Rob 300	ert A. P West Mc	umpl ntg	hrey Fi omery	uneral Avenue	Home/
	707 e d	- 1	Very,) fe	pla		$0335 \mid R$	ockvi	lle,	Mary	land	2085 0- 2	850			
			23a. Part 1. Enter the die ase, or shock, or heart failure. Li	one	cause on ea	ach line.	ith. Do not en	er the mod	e or ayın	g, such as	cardiac	or respiratory arre	Sī,		Approxir Interval I Onset ar	Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			Esoph	ageal	Can	cer					2 Yea	ars
	Examiner			1	Due to (or as a conse	quence of):									
		Ē	Sequentially list conditions, if any, leading to immediate	b	Due to (d	or as a conse	quence of):									
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.												
ĵ.	be executed ician and burial-transit	Exa	resulting in death) Last		Due to (d	or as a conse	quence of):									
00/00	cate be executed physician and the burial-transit	dical		d.												
Ď	ng ph ng ph	Med	IF FEMALE:	1												
ב ב	ith ce itendi	hysician/Med	23b. Was decedent pregnant in the past 12 months?	230	1 ☐ Live bi	come of pregn rth 2 - Fet	al death 3[∃Ectopic pr	egnancy				23	Bd. Date of del	livery Day	Year
5	e dec	sici	1 Yes 2 No		4□ Pregna 9□ Unkno	ant at time of o wn	death 5	Other (sp	ecity)					WOITH	ou,	1041
Ĺ	The law requires that the death certificate te has been signed by the atlending phys age 2 should be detached for use as the	Δ.	Part II. Other significant condition	ns contr	ibuting to de	ath but not re-	sulting in the u	nderlyina c	ause auv	en in Part I		23e Did toba	acco usi	e contribute to	the cause of	of death?
n n	signe signe	l by	Tarris only organization				outing in the		auco giri	J	*	1 ☐ Yes			robably 4	
, and a	w requir been si should	ompieted											1		Anna Singia	
ย	has has	mpi										24a. Was an autopsy perform	ed?	24b. Were at prior to death?	completion of	f cause of
NII A		O	25. Was case referred to medical										No	zeY 🔲 t	2 No	
=	Physician: The tar this certificate has ral director, page 2	o Be	examiner? 1 Yes 2 X No	Hos	spital:	npatient 2	ER/Outpatier	nt 3 🗍 DC	Othe			n <i>(Check only one</i> me 5 ∏ Resider		Other (See	o (fu)	
5	유무교	n: To	27. Manner of Death	-	28a. Date o	f Injury	28b. Time o		8c. Injury	at		28d. Describe how			city)	
5	nding Phy th. : After thi s funeral	tioi	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		(Monti	h, Day Year)	Injury	М	Work 1 □ '	<br Yes 2 ☐	No					
VISIOI	Atter r dea ector by the	ifica	3 Suicide 6 Could r		28e. Place	of Injury - At h	nome, farm, sti	reet, factory	, office	-		28f. Location (Stre City or Town,	et and	Number or Ru	ural Route N	umber,
5	s afte el Dir	Certification:	1		Danuin	.g, e.c. (3peci						ony or rown,	Jiai6)			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer											and due to the car ed at the time, dar				e(s)
	the H iin 24 the Fi	ledical	one)		and mann		acion and/or in				JUUUIT					
	To T	3	29b. Signature and title of certific) 1	1		290	. License	number		29	d. Date	signed (Mont	n, Day, Year)
	11								D	00332	293			May 6	, 200.	5
1	12		30. Name and address of person													
	0		Frederick P. Sm 31. Date filed (Month, Day, Year)	ith	M.D. 5	5454 Wi egistra ∮ Sign	Lsconsi) Che	evy Chase	<u>M</u>	larylan	d 2081	L5
	Sta	ite	The same than th			/	W	Ano	All I							

		•	For State Registrar	State of Maryland		artment tificate			and M		giene Reg. No. 0	05	1592	2
	Physici /Medic			W. Rathell						2. Date of Dea Month Ma	y 9, 2		3. Time of 1 8:30	
	Examin Funeral		4a. Facility Name (If not institution, give str Shady Grove Advent 5. Social Security Number 6. Sex	ist Hospital 7. Age (In yrs. las	st birthday)		ockv	ille If Under a		8. Date of Birt (Month, Da October	Мо	ntgome 9. Birthp	ry lace (State or	r Foreign
	Director		218-05-2266	1 2 ☐ F 84	Yrs. Town or Lo		Days	10013	NATION.	October :	30, 192		ryland Od. Inside City	
	h the Mary	irector	Maryland Montgomer 10e. Street and Number	y Ro	ckvil	le 10f. Zip	Code				10g. Citizen	of What Coun	1 X Yes	2 🗆 No
336	filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or Items 23a or 28e-f show ent, the Medical Eraminat must be notified at	by Funeral Director	303 Farragut Avenu 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	e . Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give WW II Year or Dates:				spanic Orig n, Mexican Specify:	gin? (Spe I, Puerto I	cify Yes or No Rican, etc.)	- 14. F	ited S Race - Americ Black, White,	ean Indian, etc.	
21215-0036	d within 72 hou glene. Ir then "neture the Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12	tion completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us Sale	k done d e retired)	uring most	t of workii	ng		of Business/Inc	ustry	
Maryland 2	hould be filed d Mental Hyg narked othe natic event,	Be	17. Father's Name (First, Middle, Last) Donald Rathell 19a. Informant's Name/Relationship (Type)	Print)	19h Mailir	ng Address		Maude	E.	(First, Middle, Porter			(Code)	
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Janet Moore / Daugh 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Rer '4 □ Donation 5 □ Other (Specify)	ter 20b. Pla	3129 Ice of Disponderery, crem Mon Creman	139th sition (Nam natory or ot tgome torium	Avenue of the place	nue,	S.E. May 20		nish, V	Washing on - City or To ethesd	gton Sown, State	98290 yland
Ball	permit Depar Impor any in		21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complica	M01420	Re 3		A. Pu st Mon	mphrey ntgome:	7 Fune ry Av	eral Home		lle, In , Maryla	c. and 2085 Approximate Interval Betw	
68760,	Physician (Medical Examiner) And the attending physician and detached for use as the burial-transit	lical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	ence of): R/W, ence of):	PSI ARY	S	RAC	<i>T</i>	i NFE	ectn	0 N	Onset and D	eath
.O. Box 6	the death certific / the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	Ectopic pre						Date of delive Month	· .	'ear
s, D	The taw requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contr	ibuting to death but not result	ting in the u	nderlying ca	ause give	n in Part I.		23e. Did to		contribute to th	ne cause of de ably 4 ∐Ui	
Vital Record		Completed								1 ☐ Yes	med? 2000	death?	psy findings a mpletion of ca 2 No	ivailable iuse of
of	ding Phys	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 Xho 27. Manner of Death 1 Actural 5 Pending investigation		R/Outpatier 28b. Time of Injury		8c. Injury Work	or: 4 □ Nu	rsing Hor	(Check only one 5 ☐ Residence Page 1986). Describe h	dence 6 🗆		0	
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory	, office		2	28f. Location (5 City or Tox		imber or Rura	l Route Numb	oer,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Exemine one)	cien: To the best of my know of: On the basis of examination and manner stated.	riedge, deati on and/or in	vestigation,	in my op	inion, dea	d place, a th occurre	ed at the time,	date and plac	ce, and due to	the cause(s)	
<i>(</i>)		×	29b. Signature and title of certifier	Poor, a	40	0	D D	5 7	124			TID		
	0 / 0		30. Name and address of person who com Truong Bao, M.D.				rac	e, Ge	rman	town, M	larylar	nd 208	374	
	Sta Registi		31. Date filed (Month, Day, Year) 1 1	13219 Execution 2005	75.									

			For State Registrar	State of Mary	•	artment of F		ntal Hygien	UUJ	15922
	Physici	an	1. Decedent's Name (First, Middle, Last)	Putt H		imodio or		Date of Death Month Date		3. Time of Death 5 09:15 AM
	/Medic		4a. Fecility Name (If not institution, give s			4b. City, Town, o	r Location of Death		c. County of Deatl	
	Examin	er	BAYVIEW MEDIC		TER	BALT	MORE		BALTI	MORE
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year	9. Birti Co	pplace (State or Foreign untry) Land
	D		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation		<u> </u>		10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show Jisal Examirer must be notified at	tor	MD n/a		Baltim	ore				1 XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
	s 23a		4312 E. Lombar		- 11.6	21224	lineania Orinina (Speci	US	14. Race - Ame	ican Indian
	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	'	f Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri	can, etc.)	Bfack, White	, etc.
21215-0036	ours al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2⊠No	Specify:		Specify: Wh	
15-(n 72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of working		Kind of Business/	ndustry
212	d within giene. rr than "	omb	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	e maker		I	n own	nome
	be filed within 72 ho ntal Hygiene. od other than "natur event, Ire Mi Jish	Be	17. Father's Name (First, Middle, Last)	7-11:-1	h - 6		18. Mother's Name (. 1
Maryland	Mer Mer arke	7	George Walter 19a. Informant's Name/Relationship (Type	Zollini		na Address (Street	Julia and Number or Rural P	E . Route Number, City	Smi	
	and 2 sho lealth and m 27 is m		Martin P. Ruth				oard Stre			
ore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce) Dat	e 20c. l	_ocation - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of ance.		* 4 ☐ Donation 5 ☐ Other (Specify)		Greenmo			2005Bal	timore,	Maryland
Bal	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	θ	J	Name and Addre	I. Zannin	o Jr. Fu	neral	Home
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the					T Dall	Approximate Interval Between
J.	Pnysician		Immediate Cause (Final disease or condition	META	STATIC	LUN	JG CAN	ICER		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
	-35 6	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence offic					
	cuted nd ransit	Examiner	that initiated events							
,092	ite be executed ysician and ne burial-transit	cal Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
687	9 K									
Вох	death certifica e attending ph id for use as th	an/M	23b. was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnanc	v		23d. Date of def	*
Ю.	at the deal by the att	Physician/Med	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4☐Pregnant at tim 9☐Unknown		Other (specify)	,		Month	Day Year
s, P.	de de	by Ph	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	w requires been sign should be							1 ☐ Yes	2□No 3□Pr	obably 4 Nnknown
of Vital Record	e law n has be ge 2 sh	Completed						24a. Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of
alF			25. Was case referred to medical				GC Place of Dogsth	1□ Yes 2NN		2 No
Ζ	Physicien: this certific ral director,	o Be	eyaminer?	lospital:	2 ER/Outpatier	nt 3 DOA Ott	26. Place of Death (o 5 ☐ Residence	6 □Other (Spe	cify)
		on: T	27. Manner of Death 1 Naturaf 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	28c. Inju		d. Describe how inj		
Division	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 □ Suicide 6 □ Could not be	28e. Place of Injury	At home farm et		Yes 2 □ No	f. Location (Street a	and Number or Ri	iral Route Number
Div	i Dife	Certification:	4 Homicide determined	building, etc. (S	Specify)	cat, factory, office		City or Town, Sta		
	To the Hospital or within 24 hours after To the Funerel Dircompletely filled in	edical C		sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in					
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and maintai stated	-	29c. Licens	se number	29d. D	ate signed (Mont	n, Day, Year)
			Fleralis	mle, M	0	DO	06 1358	3 0	5/09/	2005.
1	1		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type.	Print)		, ,	12711	
4	Sta	ata.	31. Date filed (Month, Day, Year)	impleted cause of death 2N A GN 32. Registr's 12005	Signature B	172111	nukt, 1	4) 2	1224	
	Regist		MAY 1 1	2005 > Ken	EMER &	pole				

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY Year **Physician** 10 2005 11:55 AM WILLIAM F. SCHOENHUT /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE COUNTY CATONSVILLE FREDERICK VILLA NURSING HOME Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1)X M 2□ F Pennsylvania 93 **Director** 180-09-2110 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example at most and once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Catonsville Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21228 6263 Gilston Park Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married
3 Widowed 4 Divorced 1♥ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: White Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) Bread Industry Salesman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ferenbach William George Schoenhut ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Dayesford Blvd. Berwyn, Pa. William Frederick Schoenhut 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Md. Bayview Crematory, Inc. 5-11-05 ⁴ 4 □ Donation 21. Signatur of Funeral acroice Licens 22. Name and Address of Facility McCully-Polyniak Fun. Home P.A. MO0922 Pasad na Md 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician none 1) b (Muchine Pulmonary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 DN0 Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No nours after death.
Ineral Director: After this
y filled in by the funeral di 27. Manne Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 29a. Certifiet 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Mille M D 1766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mille Street Sinte Kaymond Main 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 1 2005 Registrar

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artmen rtificat			ind Me		giene	1115	15924
	Physici /Media		Decedent's Name (First, Middle, Las RONALD	SANC						2. Date of De Month MAY	08,	2005	3:00 am
	Examir	er	4a. Facility Name (If not institution, give Spa Creek Cen		er)	4b. City,		Location o				County of De Anne A	
	Funeral Director		Social Security Number 6. S		Age (In yrs. last birthday 42 Yrs.	If Under Months		If Under 2 Hours		8. Date of Bird (Month, Da June /	, 196	9. B	irthplace (State or Foreign Country) W Jersey
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, the Marical Extracting the notified at ance.	ed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 7876 W. Riversi 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	de Drive 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	Iv No is:	dena 101. Zip	21.1 dent of His cify Cubar 2 No	Specify:		ify Yes or No ican, etc.)	•	U.S.A. 14. Race - An Black, Wr Specify:	nerican Indian, lite, etc. White
Baltimore, Maryland 21215-0036	ad within 72 rgiene. er than "na is, the Madic	Completed by	(Specify only highest gra	de completed) College (1-4	or 5+) (Give	o kind of wo DO NOT us Owner	rk done d	uring most					Inc. ansportation
yland	ould be file Mental Hy uarked oth	To Be (anchez			(2)	M	ildre		sell	.0	7-0-4)
Mar	d 2 sh ith and ith and 27 is m treum		19a. Informant's Name/Relationship (19a. Robin Sanchez (Wi			•				Route Numbers. Pas			yland 21122
more,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Sta	20b. Place of Disp	osition (Nar matory or o	ne of other place	9)	Da 5-09-	ite	20c. Lo	cation - City of	or Town, State Maryland
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	Court	M	2. Name ar CCull 3204	nd Addres V-Po Mount	s of Facility Lynial Lain	Fun Road,	eral H Pasad	ome ena,	P.A. Maryl	and 21122
3760,	cate be executed by Section and Carlo Britansit the britan-transit	dicai Examiner	234 Part 1. Enter the disease, or com shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a consequence of): as a consequence of): as a consequence of):	An	4pop	SCL MA	cardiac or	respiratory ai	rest,		Approximate Interval Between Onset and Death
P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		n 2 ☐ Fetal death 3 i t at time of death 5 i	⊒Ectopic pr ⊒ Other (sp					2	23d. Date of d Month	elivery Day Year
rds, P.	quires that I nn signed by uld be deta	ed by Ph	Part II. Other significant conditions o	ontributing to deat	h but not resulting in the i	inderlying c	ause give	n in Part I.			obacco u /es 2[to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law re ate has bee page 2 sho	Complet	C		/					24a. Was autop perfo 1 Yes	an sy rmed7 2 X No	24b. Were a prior to death?	
Vita	lclen: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o		70	
on of	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of l (Month,		_	8c. Injury Work	at A Pour	28	e 5 🗌 Resid Bd. Describe h			ecify)
Divisi	of or Attentation after deal	Certification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, farm, st , etc. (Specify)	reet, factory	y, office		28	3f. Location (S City or Tox			Rural Route Number,
	ns Hospite n 24 hours ne Funerel	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the be niner: On the basi and manner	est of my knowledge, dea s of examination and/or in stated.	th occurred evestigation	at the tim , in my op	e, date and inion, deat	d place, ar h occurred	nd due to the	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
	Tot	٦	29b. Signature and title of certifier				D C	onmper (25	8	29d. Date	e signed (Mor	oth, Day, Year)
[) (30. Na daddress of person who ADITYA CHOPKI 31. Date filed (Month, Day, Year)	4, m.D.	of death (Item 23a) (Type 1000 RtdgCl istrat's Signature	n	. Sk	.231	Phn	apdis	3,m	D214	0/
	Sta Registi		A S S	1 2005	Been &	Los	de)						

		•	For Stete Registrar	State of Ma	aryland / [rtment of I				giene)	05	15925
			Decedent's Name (First, Middle,	Last)			- 1	**		2. Date of Dea			3. Time of Death
	Physici		GERTRUDE				STERI	VER		Month MAY	Day //	2005	0205 AM
}	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town,			14111		nty of Death	1
	Examin	E			WA CEN	מיביו	BALTIMA	DE	M	D			
	Funeral		JOHNS HOPKINS B. 5. Social Security Number		(In yrs. last bir		BALTIM 0 If Under 1 Year	If Under		8. Date of Birtl (Month, Day	h	9. Birthp	lace (State or Foreign
	Funeral Director		219-18-7395	1□M 2XF	79	Yrs.	Months Days	Hours	Min.	Month, Day October 5	y, Yea <i>r)</i> 5.1925	MD.	
			Usual Residence of Decedent								7.525		
	ylan		10a. State 10b. County		10c. City, Tow		cation					1	0d. Inside City Limits
	Ma-f.	to	MD Balti	nore	Dunda	alk							1 ☐ Yes 2 XNo
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cour	itry?
	th wi	alc	6846 Broening Re	oad			21	222				USA	
	dea dea	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Yes, specify Cub	Hispanic Or	rigin? (Spe	ecity Yes or No-	14. F	Race - Americ Black, White,	
ထွ	or it	五	1 ☐ Never Married 2 Marrie		lo		☐Yes 252 No			,			
Ö	within 72 hours after death with the Maryland ene. then "netural", or Itams 23e or 28e-f show the Medical Examiner must be rediffed at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1							MIIT	
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12	hen hen	mp	Elementary/Secondary (0-12)	College (1-4or 5				30)			•	***	
7	filed v Hygie other t	ပိ	10 years 17. Father's Name (First, Middle, Li	est)	L	lous	ewife	18 Moth	er's Name	(First, Middle,		n Home	
Maryland 21215-0036		Be		,						Niemye:			
Ž	hould d Me mark mark	P	John Niemyer 19a. Informant's Name/Relationshi	n (Tyne Print)	19h	Mailin	g Address (Stree					wn State Zin	Code)
<u>N</u>	d 2 s th an 7 is trau		Eugene Sterner	Husbar			Broening				-		,
ď,	1 an Heal em 2		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of	Ī		Date		on - City or To	wn, State
altimore,	permit. Pages 1 and 2 should be Depuriment of Health and Menta Important: If item 27 is marked any njury or other traumatic es 2005.		1X Burial 2 ☐ Cremation		Cardens	ry, cren OF	natory or other pla Faith Ceme	eterv 1	May 1	3,2005	Rose	dale, M	MD.
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Ba	Dep Imp any once			12 h			Name and Addr Onnelly						21222
			23a. Pa 1. Inter the disease, or o	omplications that caused	the death. Do		110 Soll					K, Ma.	Approximate
ls.			stock, or heart failure. List o	nly one cause on each lir	ne.						,		Interval Between Onset and Death
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	ted nsit	Examiner	Cause (Disease or injury) - John (507	1,50	0 0				1.0	11- 11-10
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8760,	The law requires that the death certificate ba exacuted the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dlcal E		a Derich	eral y	u	ular di	case				0	NE YEAR
687	ficate p phy.	edlo											
Вох	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1 —				23d.	Date of delive	ery
m	death a atte d for	cia	in the past 12 months?	4□Pregnant at	2 Fetal death time of death		Ectopic pregnand Other <i>(specify)</i>					Month	Day Year
o	that the de sed by the a detached f	hys	9 Unknown	9□ Unknown									
σ,	res that igned to be det	by P	Part II. Other significant condition	s contributing to death b	ut not resulting i	n the ur	nderlying cause g	iven in Part	I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
g	quire n sig uld b									1 🗆 Y	res 2□No	3 Prob	abiy 4 T Unknown
Records,	aw requir as been si 2 should	Completed								24a. Was	an 24	b. Were auto	psy findings available
æ	he las	mo									rmed?	death?	mpletion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical		· · · · · · ·			26. Plac	e of Death	Check only o		1 103	2.00
>	Physician: r this certificatal director.	To B	examiner? 1 ☐ Yes 2 ∰ No	Hospital:	nt 2□ER/O	utpatien	t 3 DOA	ther: 4 🗆 N	ursing Ho	me 5 ☐ Resid	dence 6 🗆	Other (Specif	v)
ō	tending Physician: The leath. tor: After this certificate hathe funeral director, page		27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	28c. Inju			28d. Describe h			
ion	Attending F r death. ector: After by the funer	atio	1 ■ Natural 5 ☐ Pending 2 ☐ Accident investiga		y routy	Injury		Yes 2□]No				
Division of Vital	or Attendated death Director:	iflo	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, fa	arm, str	eet, factory, office	•		28f. Location (S City or Tox	Street and Nu	mber or Rura	l Route Number,
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	one)	and manner sta					aar occurr				
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	1		mmuseel	, m.D.			RES	-000		1	MAY 1	1, 200	5
; ()('		30. Name and address of person w										
1			MELISSA MUNSELL	THE THINS H	OPKINS F	VYAE	IEW MEDICA	IL CENTE	R 49	to easter	JAVE B	ALTMORE	MD 21224
	Sta		31. Date filed (Month, Day, Year)	THE THINS H 32. Registr V 1 1 2005	ar's gnature	, 1	y Good						
	Regist	ar	ΔM	y 1 1 2005	Julian		-/						

			1- State of Maryland Department of Health and I state of Maryland Department of Health and I tem4b-c, 20c, 24aper physin 6343 Certificate of Death	Mental Hy	giene Reg. No:	005	15926
			Decedent's Name (First, Middle, Last)	2. Oate of De	ath		3. Time of Death
	Physici /Medic		MARIE ELIZABETH SLADE	05/06	Day 2005/		9:45 PM M
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			County of Dea	
			House of Jubilee Fallston Raltimore			Altimo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Da	y, Year)		thplace (State or Foreign ountry)
	Director		213-05-2620 93 Trs.	10/06/1	911	Ma	ryland
	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Man,	tor	MD Baltimore Kingsville				1 ☐ Yes 2 💆 No
	h the	lrec	10e. Street and Number 10f. Zip Code		10g. Citiz	zen of What C	ountry?
	th wit	alD	11211 Pfeffers Road 21087		U.	S.A.	
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	- 1	14. Race - Am Black, Whi	
36	s afte , or it	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify:			Specify:	
21215-0036	hour turai'	q pe	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b Kir	Wr nd of Business	ite
5	in 72 an" r	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	rking	TOD. IN	io oi busiliess	viriousity
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	s filed within 72 hours after death with the Maryland ul Hygiene. other then "naturel", or items 23e or 28a-f show vent, the Medical Examiner must be notified at	BeC		ne (First, Middle,			
/lar	uld be Menta Irked tic ev	To B	Herman Schwartz Caroli	ne Deitz	3		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other traumetic event, the Medical Examinat must be notified at once.	'	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ıral Route Numbe	er, City or	Town, State,	Zip Code)
	and and n 27 n 27 ner tr		Carolyn L. Appel (neice) 11211 Pfeffers Road				
altimore,	ges 1 l of H if ites		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		cation - City or Hall	Town, State
Ë	Pag tment tent: jury c		'4 Donation 5 Other (Specify) St. Michael Luth. Church Cerr. 05/1	10/2005 🕂	Balt.	imore,	Maryland
Ball	permit Depari Impor Impor eny in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.				
	20 % 9 O	_	11750 Belair Road			, Mary	land 21087
Н			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		rest,		Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence of):				
į,		-	Sequentially list conditions, if any, leading to immediate b. ISECAST CANCER Due to (or as a consequence of):				YEARS
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	dea he att	sicla	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			Month	Day Year
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Ś	res th signed be d	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dia to			o the cause of death?
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ec	e 2 sl	Completed by		24a. Was autop	SV	prior to	utopsy findings available completion of cause of
듄	: The			150 10 s	rmed? 2 .0 No	death?	2 □ No
Division of Vital Records,	icien certif	Be	examiner/	ath (Check only o			
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on	ding th. Afte	tlon	1 XNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		,,		
/isi	Atten r dea sctor	ifica	3 Suicide 6 Could not be	28f. Location (S	Street and	Number or R	ural Route Number,
á	after of Direction of the bin the contraction of the bin the	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tow	m, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medicel Exempler: On the basis of examination and/or investigation in my online, death occur				
	he Hi in 24 he Fi plete	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.				
	To t To t	Σ	29b. Signature and title of certifier 29c. License number			signed (Mont	
•			Wind Klory MD D31295		5-1	9/05-	21239
	1		1.30 Name and address of person who completed cause of death (Item 23a) (17be, Phil)		734	set mi	2/239
	0		WENDY KLUESZ, MD GOD SAM HOSO, TAL SGOT LGO 31 Data filed (Month Day: Yazz) M 32 Banistrate Signatural	H REEK	736	UD PU	268 4
	Sta Registr		WENDY KCOESE, MD COOD Som HOSDITAL SUCT LOC 31. Date filed (Month, Day, Year) 32. Registra's Eignature				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2005 **Physician** PHILLIP SEYDA 4:15 A DANTET. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crisfield McCready Memorial Hospital Somerset If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) December 24, 1940 Maryland 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1⊠M 2□F Months 64 Director 525-88-5353 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 7 is markad other than "natural", or Items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1X Yes 2 No Director Somerset Crisfield Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 44 Maryland Avenue 21817 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 XYes 2 □ No 1959-1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify 3 Widowed 4 Divorced Year or Dates: 1962 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is markad other than "r filed within Elementary/Secondary (0-12) College (1-4or 5+) Seafood Company 10 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Rae Lane Robert Ralph Seyda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 sint of Health an 44 Maryland Avenue - Crisfield, Maryland 21817 Patricia Seyda (Wife) othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ital
any injury or oth 1 N Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) May 10, 2005 Crisfield, Maryland unnyridge Memorial Park 21. Signature of Funeral Spice of Section of Mary Beth Bradshaw—Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home <u> 306 W. Main Street - Crisfield, Maryland 21817</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Longestive HEart Partire Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 W Eumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-translt Swire Anaenna Due to (or as a consequence of): attending physician Box 68760. certificate be Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, λq pp 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 1 Inpatient 2 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To tha Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of celtifier D-15715 May 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Gill, M.D. 26423 Burton Avenue - Crisfield, Maryland 21817 31. Date filed 32. Registrar's Signature State Registrar

		State Unpend Item 23a&27 1 - State Unpend Item 23a&27 1. Decedent's Name (First, Middle, Last)		Timeate of Death	Reg.	No. 3. Time of Deat					
Physici		James Grover Slunt, J	r.			Pay 2005 08:23 A					
/Medic Examin		4a. Facility Name (If not institution, give street and 6706 Ducketts Lane	Death	4c. County of Death Howard							
Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birthday 41 Yrs.		Hrs. 8. Date of Birth (Month, Day, Ye Dec. 6, 1						
* =		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Lir					
a-f sh	tor	MD Howard		Elkridge		1 ☐ Yes 2 🔀					
or 28 8 rol	Jirec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?					
8 23a	rail	6706 Ducketts Lane		21075		nited States					
it of health and Mental Hygens, or contains 23a or 28a-f show are of their 21 is marked other than "natural", or item 21 is marked other than an or other traumatic avant. The Marical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes,	s 2 📉 No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
e. An "natur Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	working 16b	ng 16b. Kind of Business/Industry							
Hygiene. other than "r ant, the Med	Con	12		Chemist		Geo Tech Company					
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d Mer narke	၉	James G. Slunt, Sr. 19a. Informant's Name/Relationship (Type, Print)			ley M. Whitt						
traul		Hilda H. Slunt Wife		G and law and Number o							
Department of Health a Important: If itam 27 is any injury or other tra		20a. Method of Disposition Burial 2 Cremation 3 Removal fro	m State	matory or other place)	Date 20c.	Location - City or Town, State					
ortan		21. Signature of Funeral Service Scenses		S Cemetery 5- 2. Name and Address of FacilityA	9-2005 C1	arksville, MD					
3 1 2		White work 18	LUX 1/20/3/1	328 Sulphur Spr	ing Koad. Ar	burus. MD 21227					
	7	a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the death. Do not en	ter the mode of dying, such as car	diac or respiratory arrest,	Approximate Interval Between					
physician and sthe burial-transit	Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulasass of injury that initiated events c.	o (or as a consequence of): o (or as a consequence of): o (or as a consequence of):								
ed by the attending detached for use a	Physician/M		Physician/M	Physician/M	Physician/M	Physician/M	in the past 12 months?	gnant at time of death 5 [□Ectopic pregnancy □ Other (specify) Inderlying cause given in Part I	23a Did tohacce	23d. Date of delivery Month Day Year
D a	0			2 No 3 Probably 4 Unknow							
ate has	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1X Yes 2 □ N						
	0	examiner?	Inpatient 2 ER/Outpatier	Other	Death (Check only one)	6x3Other (Specify) Scene					
After th funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Month, Day Year 28b. Time of Injury Mork? 1 Yes 2 No										
18 90 I	O	4 nomicide buil	e of Injury - At home, farm, str ding, etc. <i>(Specify)</i>		City or Town, Sta	et and Number or Rural Route Number, State)					
ha Funaral I	edicai	2 Innedical Examiner: On the	ne best of my knowledge, death basis of examination and/or in nner stated.	n occurred at the time, date and playerstigation, in my opinion, death or	ace, and due to the cause(ccurred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)					
To tha complet		29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)					
		Threat Friedlesell		OCME	Ms	ay 05, 2005					
		30. Name and address person who completed ca			116	iy 05, 2005					

			1 - For State Registrar		State o	of Mar	yland		artmen rtificat					Reg.	401)5	15929							
	Physici /Medic		1. Decedent's Name (First, Mi Katherine Is		e Sil	fies							2. Oate of	Death	Day De	005	3. Time of Death							
	Examin	ier	4a. Facility Name (If not instity Mary Jana)	Ger	RROU	C A	05/	st birthday)	4b. City, Ba	eti	Location of	2	8. Date of	/ Birth	4c. County		lace (State or Foreign							
	Funeral Director		5. Social Sèsurity Number 215-16-7442 Usual Residence of Decedent	6. Sex	M 2⊠F	7. Age (86		Months	Days	Hours	Min.	June	23, 1	918	Mar	y Land							
	Maryland -f show	tor	10a. State 10b. Cou MD n/a	nty				Town or Lo	ocation							1	0d. Inside City Limits 1 ⊠Yes 2 □ No							
	a or 28e	I Direc	10e. Street and Number 1911 Harman	17.0					10f. Zip	Code 230					Citizen of V									
036	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show Jical Evaruther must be invilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Nover Ma	larried	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2 ∰ No ive				dent of Hi cify Cuba	spanic Ori n, Mexicar Specify:		ecify Yes o Rican, etc.		14. Rac Blac	e - Americ ck, White, v: Whi	an Indian, etc.							
21215-0036	within ne. ihan "	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1:	-				16a. Dece (Give life. Homer	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition luring mos)	t of work	ing	16b	. Kind of B		dustry							
Maryland 2	should be filed vid Mental Hygie markad other t matic avant, III	To Be C	17. Father's Name (First, Midde Peter Maenner	le, Last)									e Kah		den Suman									
	nd 2 sullth and 2 sullth and 27 is		19a. Informant's Name/Relation Joseph B. Cou	. ' ' '		son			•						ty or Town, yland									
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		emoval from	State	Mary Gari	nce of Disponence of Land	Veter Fores	ther place ans t		5/13,	2005/	Ow		4ills	, Maryland							
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Serv	Q	ellel.		N.	1	328 5	ulph	ur Sj	pring	g Rd 1	Balti	eral H imore	-	yland 21227							
	Physician		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)					Do not en	er the mod	n of dying	g, such as	cardiac (or respirato	ry arrest,			Approximate Interval Between Onset and Death							
√ ′09	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical Exal	by Physician/Medical Exal	by Physician/Medical Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to	(or as a control of the control of t	conseque	di ence of):	verl v (i en	R	ect	tal	pru	olaps	36						
.O. Box 6					by	by	by	by	ysiclan/Me	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2:		birth 2 nant at tir	Fetal	death 3	Ectopic pr Other (sp					_		te of delive
Ω.	w requires that been signed b should be deta								Part II. Other significant cond	litions con	tributing to d	leath but	not result	ting in the u	1	ause give	en in Part I			Oid tobaco		ribute to th	ne cause of death? ably 4 Unknown	
Vital Records,	The ate h page	Completed	SIP Vo	le-	noke	~							a	Mas an autopsy performed es 2	1	Were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of							
f Vita	ysician: is certific director,	To Be (25. Was case referred to med examiner? 1 X Yes 2 □ No		ospital:	Inpatient	× E	R/Outpatier	nt 3 DC)A Othe	ar.		n_(<i>Check or</i> me 5□F		e 6 □Oth	er (Specify	v)							
)ivision	ing Yfter une		L	stigation	28a. Date (Mon	of Injury oth, Day		28b. Time o Injury	f 2	8c. Injury Work 1 🔲 \	at ? /es 2 🗆	ĺ	28d. Descr	ibe how i	njury occur	red								
	tal or Attand rs after death al Director: /	Certification:		ild not be ermined		e of Injury ling, etc.		ne, farm, st	eet, factory	r, office				on (Street Town, St		er or Rura	l Route Number,							
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	(Check only	al Examir			xamınatio		vestigation	, in my op	inion, dea			me, date	and place,	and due to	the cause(s)							
)	To with Com	×	29b. Signature and title of cer	rfiel	ingh	M	D		290	. License	0 /	418	8-6	29d.	Date signe	o (Month,	Day, rear)							
	4		30. Name and address of pers	NG	H, K	ND		912	Print)	1, 3	365	F.	BI	+LT	, M	D 2	1211							
	Sta Registr		31. Date filed (Month, Day, Ye MAY 1		100	Registrar'			while)															

State of Maryland / Department of Health and Mental Hygien@ [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 4, Year Joseph 2005 Gerbrum Sellick 2:38 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min **X**XM 2□ F 164 18 4234 83 Yrs. Director 1921 Dolyestown, PA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Mudical Examinar must be notified at Maryland Prince George's Forestville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7211 Earl Drive 20747 United States or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status a filed within 72 hours after d I Hygiene. other than "natural", or Item Armed Forces: XXYes 2 ☐ No If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) 5t Manager Federal Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental H int: If item 27 Is marked of Crosby Sellick Eva (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmen Sellick (Wife) 7211 Earl Drive, Forestville, Maryland 20747 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Xremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. ō Lee Crematory May 6, 2005 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral/Service Licensee Alexandria Ferry Rd, Clinton

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alexandria Ferry Rd, Clinton, MD 20735 Immediate Cause (Final disease or condition resulting in death) Pnysician MENCE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as cons vuence of): The law requires that the death certificate be executed Due to (or as a consequence P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, UYO XW MONOM 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No. 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death.
I Director: Af
id in by the ful investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide vithin 24 hours a To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registre s Signature Registrar

ADH
SHANNON SULLIVAN
05-3226

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

- 32	226		1- For State of Registrar		artment of Health and rtificate of Death	Mental Hygie	/11115	15931
	Physic		1. Decedent's Name (First, Middle, Last) Shannon C. Sulliva			2. Date of Death	Day 2005 Year	3. Time of Death
)	/Medi Exami		4a. Facility Name (If not institution, give street and num UNIVERSITY HOSPITAL SHO	nber)	4b. City, Town, or Location of Dea BALTIMORE CITY		4c. County of Death	
	Funeral Director			7. Age (In yrs. last birthday) 15 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir			place (State or Foreign ntry) y and
121	Maryland a-f show	tor	10a. State 10b. County Md n/a	10c. City, Town or Lo Balti				10d. Inside City Limits 1 X Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 3706 Garrison Blvd.		10f. Zip Code 2 1 2 1 5	10g.	Citizen of What Cou	ntry?
	d 2 should be filed within 72 hours atter death with the Maryland th and Mental Hygiene. 77 Is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinating that the recified at	b		2 /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Was Decedent of Hispanic Origin? (. IYes, specify Cuban, Mexican, Pue I□ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: B 1 a	etc.
	filed within 72 ho Hygiene. other than "nature ent, the Medicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-	40f 5+)	ient's Usual Occupation kind of work done during most of wo DO NOT use retired) tudent	В	Baltimore City	
yland	should be file nd Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Donald Sullivan		Jill E	me (First, Middle, Maid). Eubank:	s-Sulliv	an
imore,	permit. Pages 1 and 2 sho Department of Health and I Important: If item 27 Is ms any injury or other traums once.		19a. Informant's Name/Relationship (Type, Print) Jill Eubanks-Sullivan 20a. Method of Disposition 1	Mother 3 20b. Place of Disposementary, crem	g Address (Street and Number of R 706 Garrison E sition (Name of natory or other place) 1 Cemetery 5-1 Name and Address of Facility	Blvd. Bal- Date 2000 6-05 WG	to. Md 2 Location - City or To	1215 own, State
	Medical Examiner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissert or injury that initiated events c.	used the death. Do not enter th line. I CA TONS as a consequence of): I as a consequence of):	200 Liberty Ro or the mode of dying, such as cardia of multiple	c or respiratory arrest,	allstown	MD 2113 Approximate Interval Between Onset and Death
.O. Box (death certitic e attending p id for use as	Physician/Med	in the past 12 months?	nt at time of death 5□	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
rds, P	signed signed d be de	by	Part II. Other significant conditions contributing to dea	th but not resulting in the un	derlying cause given in Part I.		o use contribute to th	e cause of death?
Division of Vital Rec	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
	To the Hospital or Attending Physician: " within 24 hours after death." To the Funeral Director: After this certifica completely tilled in by the funeral director, p	Il Certification; To Be	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	Injury Day Year) 28b. Time of Injury 8-05 21.30 I Injury - At home, farm, stree, etc. (Specify)	3 □ DOA Other: 4 □ Nursing F 28c. Injury at Work? M 1 □ Yes 2 ☑ No et, factory, office	28f. Location (Street City or Town, Sta	jury occurred vedestrian and Number or Rura ite) 3800 blk d. Baltimor	Struck Route Number, P, MD 21215
	To the Hospital or At within 24 hours after or To the Funeral Direct completely tilled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manne 29b. Signature and title of certifier	is of examination and/or inve	occurred at the time, date and place astigation, in my opinion, death occu	irred at the time, date a	nd place, and due to eate signed (Month, L	the cause(s) Day, Year)
	5		30. Name and address of person who completed cause	of death (Item 23a) (Type, P				
	Sta Registr	.18	31. Date filed (Month, Day, Year) 32. Rev	gistrar's Signature				

			Plea	ase Type or Pri			delible Ink. artment of H		_	_	ble.		
			1 - For State Registrar	State of M	arylariu		tificate of		WETHAI FTY	Reg. No	05	15020	
			Decedent's Name (First, Middle						2. Date of D Month	1101 440	Year	3. Time of Death	
	Physici /Medic		George	B. Sterl	ing				MAY	9.	1005	10:35 PM	
	Examin		4a. Facility Name (If not institution										
	Funeral		5. Social Security Number	6. Sex 1 🛣 M 2 🗆 F	e (in yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year)	Coun	ace (State or Foreign	
	Director		194-10-9419 Usual Residence of Decedent		92	115.			Dec. 2	0, 1912	Mar	yland	
	rryland show	_	10a. State 10b. County	/		Town or Lo					10	Od. Inside City Limits	
	he Ma 8a-f	ecto	Maryland Number	N/A		Balti				10g. Citizen of		1 XYes 2 No	
:	with t	Funeral Director	6225 York Ro	oad			10f. Zip Code 2121		ed Sta	*			
	death ms 23	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or N		ce - America	an Indian,	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show ant, it e Macilcal Examiner must be notified a	by	1 ☐ Never Married 2 ☐ Mar 3 🎇 Widowed 4 ☐ Divorced	rried 1 Tes 2 X			1 ☐ Yes 2 🛣 No		no Rican, etc.)		ck, White, 6 y: Whi		
2-C	72 ho natur	Completed		nt's Education est grade completed)		16a. Deced	dent's Usual Occup	ation during most of w	orking	16b. Kind of B	usiness/Ind	ustry	
12	be filed within 72 hatal Hygiene. Id other than "natued ovant, it e Manical	dwc	(Specify only highest grade completed) Elementary/Secondary (0-12) 6 yrs. (Give kind of work done during most of working life. DO NOT use retired) Seafood Handler							Seafo	Seafood Market		
מ	m = 0 %	Be C	17. Father's Name (First, Middle,	, Last)					ame (First, Middle	e, Maiden Sumar	ne)		
ylar		ToE		Sterling				Virg		uitt			
Maryland	12: har 7 is trau	1	19a. Informant's Name/Relations Mr. Russell C.				ng Address (Street S. Marsh			oer, City or Town, artstown			
	1 an Heal am 2 thar		20a. Method of Disposition	. Sterling -			sition (Name of natory or other place		Date Date	20c. Location			
Baltimore,	9 = 5		1 ⚠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				matory or other piac Mem. Parl		2/2005	Baltim	ore, I	MD	
alti	permit. Pag Departmen/ Important: any injury ence.		21. Signature of Funeral Service	Licensee Michael		pp ²²	. Name and Addre	ss of Facility		5305 H	arfor	d Road	
	20529		23a. Part1. Enter the disease, or	7-/	d the death		Leonard			Baltim	ore, I	MD 21214 Approximate	
	Pnysician /Medical Examiner	ıer	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ON ECTVE HEART FAICURE Due to (or as a consequence of): Sequentially list conditions									Interval Between Onset and Death	
68760 , <	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To tha Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
P.O. Box	at the death certific by the attending p tached for use as I	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)	y		1	23d. Date of delivery Month Day Year		
ds, P	w requires that been signed b should be deta	d by Pi	PROSTATE CA			_					o use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
Vital Records,	The law req	Completed by	DISEACE, ASBECTOSIS 24a. Was an autopsy performed to yes 2 Z							opsy ormed?			
I a	ician: certifica rector, p	Be C	25. Was case referred to medica examiner?						eath (Check only	опе)			
5	Physic this o	2:	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		R/Outpatien 8b. Time of				idence 6 Oth)	
0	th. After s funer	ition	1 ZNatural 5 ☐ Pendir	28a. Date of Injuring (Month, Datigation	y Year)	Injury	Wor	rk? Yes 2 □ No	200. Describe	now injury occur	100		
Division of	al or Attanding Phys after death. I Diractor: After this d in by the funeral dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, S								er or Rural	Route Number,	
	To the Hospits within 24 hours To the Funera completely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and manner stated.							cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)	
)	To the within To the comp	Me	29b. Signature and title of certifie		_		29c. Licens			29d. Date signe			
	3		30. Name and address of person	who completed cause of a	death (Item 2	3a) (Type, 560)	Print) MICHEL LOCH RA	L KAFRI VEN BIV	> BALTI	MORE, 1	113 2	1239	
	Sta Regištr	4.1	31. Date filed (Month, Day, Year,		rar's Ignatu		1 South	فرا					
							P						

		_	1 - For State Registrar	State of M	aryland /		artment o			-	jiene	in.	159	33
	Physic /Medi		Decedent's Name (First, Middle, Last,	Nancy	Jean	Smi	th			2. Date of Dea Month May	Day	2005 ^{Year}	3. Time o	f Death A M
	Exami		4a. Facility Name (If not institution, give Shady Grove Adven		ital			n, or Location	of Death			County of Death		
	Funeral Director		5. Social Security Number 6. Sec		e (In yrs. last i	birthday) Yrs.	If Under 1 Ye Months Da	ar if Under	24 Hrs. Min.	8. Date of Birth (Month, Day) September			place (State on the state of th	or Foreign
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation						10d. Inside C	ity Limits
	th the Ma or 28a-f	Director	Maryland Montgom 10e. Street and Number			Ro	ckville 10f. Zip Cod			1	0g. Citi	zen of What Cou		2 🗌 No
	death w		206 Reading Ave	12. Was Decedent	Ever in U.S.	13.	Was Decedent	20850 of Hispanic Ori	igin? (Spec	cify Yes or No-		ted Stat		
920	ours after ral', or Ite Exa⊤irre	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ f If Yes, Give Year or Dates:	40		If Yes, specify 0 1 ☐ Yes 2 🔼 I			lican, etc.)		Black, White,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, if a Medical Examinating the rottling of an once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mos tired)	at of workin	g		nd of Business/Ir	•	
nd 21	oe filed w al Hygier d other ti	Be Col	11 17. Father's Name (First, Middle, Last)				Homemak		er's Name	(First, Middle, M		Own Home Sumame)		
aryla	should bund Ment marked umatic	2	Frank Grello 19a. Informant's Name/Relationship (Ty)	oe, Print)	19	Jb. Mailir	ng Address (Str			a Falis		r Town, State, Zip	c Code)	
e, K	1 and 2 Health a em 27 is		Therese White /Dau	ghter	1	5 Ne		Street	, Che	vy Chas	se,	Maryland	1 20815	5
timor	. Pages tment of tant: If it jury or o		1 X Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)		cemet	f Hea	ven Cemet	tery	4ay 18 200	5 S	ilve	r Spring,	Marylan	ıd
Ba	permit Depar Impor any in		21. Signature of Furrieral Service License Ungletta Carrest	1	401305	30	J West Mo	ontgomery	y Aveni	ue, Rockv	/ille	ville, Inc , Marylan	c. d 20815	
	Physician	E //	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each iir	the death. Do le. catory			tying, such as	cardiac or	respiratory arre	∌st,		Approximate Interval Bette Onset and Days	ween
	/Medical Examiner		resulting in death)	Due to (or as Multi	ole Mye		ı						Jayo	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	e of):								
8760,	icate be executed physician and s the burial-transit	dlcal Ex	resulting in death) Last	Due to (or as a	a consequence	e of):								
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the butial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnal				2	3d. Date of delive	,	'ear
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	it not resulting	in the ur	nderlying cause	given in Part I.			accous	se contribute to th	ne cause of de	
Records,	sician: The law re certificate has bee irector, page 2 sho	Completed								24a. Was an autopsy perform	red?	death?	psy findings a mpletion of ca	vailable use of
r Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	ospital: 1 🔀 Inpatier	nt 2□ER/C	utpatien	3 DOA			Check only one	9)	Other (Specify		
Division of	al or Attending Physician: 1 s after death. Il Director: After this certificat ad in by the funeral director, p	atlon; T	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Time of Injury	28c. In	lury at lork? □ Yes 2 □ t	28	d. Describe hov	w injury	occurred	//	
DIVI	ital or Atturs after de ral Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)					City or Town,	, State)	Number or Rura		er,
	To the Mospital within 24 hours a To the Funeral I completely filled	ledical	29a. Certifier 1	cian: To the best of er: On the basis of and manner state	examination a	je, death nd/or inv	occurred at the estigation, in my	time, date and opinion, deat	d place, an h occurred	d due to the car at the time, da	use(s) a te and p	and manner as st place, and due to	ated. the cause(s)	
)	of the Property	₹	29b Signature and title of certifier	_			1	nse number 061681				signed (Month, 1	Day, Year)	
1	000	9	30: Name and address of person who cor Robert Kirkcaldy,				Print)		Roo!			yland 20	1050	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1	32. Registra 1 2005	Signature	H	Gast	DIIVE,	KOCK	viile,	nar	утана 20	J0 JU	

			1 - State of Maryland		artment of I			iene	5 15934
П	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Y	3. Time of Death
	/Medi	cal	Jean Lenore Schwier 4a. Facility Name (If not institution, give street and number)		45 O't T		May 9	, 2005	9:43A M
	Examir	ner	Casey House			or Location of Death		4c. County of	Death gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year		8. Date of Birth		
L	Director		505-18-5534 1☐ M 2☒F 85	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 29,	1920	Birthplace (State or Foreign Country) Nebraska
	72 hours after death with the Maryland Insturel', or Items 23a or 28e-1 show ofical Examiner must be rediffed at			, Town or Lo					10d. Inside City Limits
	Be-f s	Funeral Director			er Sprin	g 			1 ☐ Yes 2 🖾 No
	with t	Ö	10e. Street and Number		10f. Zip Code		i	g. Citizen of Wha	•
	ns 23	erai	12706 Flack Street 11. Marital Status 12. Was Decedent Ever in U.	S 13 \	209			United S	
(0	r Iten	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 212 No	13. 1	Yes, specify Cub	Hispanic Origin? (Spann, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
93	rel', o	by	3 ⚠Widowed 4 □ Divorced If Yes, Give Year or Dates:	1	☐ Yes 25€ No	Specify:		Specify:	White
5	72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	pation during most of work	ina 1	6b. Kind of Busin	•
21215-0036	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	OO NOT use retire	d)		Montgo: County S	mery
d 2	filed Hygie other		17. Father's Name (First, Middle, Last)		Secret	ary 18. Mother's Name			CHOOLS
lan	Aental	To Be	Robert Stubbs			Nettie La		algon Gamamo)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumetic event, the Madical Examiner must be retified at once.		19a. Informant's Name/Relationship (Type, Print) Robert Allen Schwier/Son	19b. Mailin	g Address (Street	and Number or Rura Street, Pl	al Route Number,	City or Town, Sta	te, Zip Code)
re,	item item		20a. Method of Disposition 20b. Pt			-	7-	Oc. Location - City	
<u>=</u>	Page nent c ent: If ury or		1	clawn Memo	sition (Name of patory or other plan rial Pari	k 200	55' R	ockville	, Maryland
Baltimore,	permit. Departr Importe any inj		21. Signature of Funeral Service Licensee M01386	Roo Roo	Name and Addre	iss of Facility Robe Inc. 300 Mary Land	West Mon 20850-28	mphrey 1 ntgomery 305	Funeral Home/ Avenue
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	r the mode of dyir	ng, such as cardiac (or respiratory arre	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Malignant Nec		Pancrea	tic Duct			Onset and Death
	Examiner		Due to (or as a consequ	ence of):					
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Ö,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last Due to (or as a consequ	ence of):					
8760	icate be executed physician and s the burial-transit	dicai	d						
× 6	death certific e attending pl d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan	icv					
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1	death 3 □I	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
о. О	at the de by the a tached	hysi	9 ☐ Unknown 9 ☐ Unknown						
ds, F	as the	by	Part II. Other significant conditions contributing to death but not result	ting in the un	derlying cause giv	en in Part I.			e to the cause of death?
Ö	w require s been sig should b	iete					24a. Was an	24h Were	autopsy findings available
		Completed					autopsy performe 1 Yes 2	prior	to completion of cause of 1?
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient 2 ☐ F		3CLDOA Oth	26. Place of Death			
	y Phys ar this aral dir	2: 10	27. Manner of Death 28a. Date of Injury	R/Outpatient 28b. Time of	3☐ DOA 28c. Injun Worl	4 Nursing Hor	ne 5 Residen 28d. Describe how		Specify)Hospice
0	Attending I ir death. ector: After by the funer	ation	1 🖾 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 □ No		many desarrou	
=	i Dift o	ertifications	3 Suicide 6 Could not be determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	pite urs arel	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating and manner stated	ledge, death on and/or invo	occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cau	se(s) and manner	as stated.
	To the Hos within 24 ho To the Functional Completely f	Mec	29b. Signature and the air certifier		29c. License			I. Date signed (Mo	
_			Ellettille	~ K	NL	11218	7	5/10)	105
Q) (0	ı	30. Name and address of person who completed cause of death (Item : Charles Harrison M.D. 6001 Munc			d. Rockvi	lle. Mar	vland 20	855
	Sta	te	21 Date filed (Month Day Year) 22 Begintrade Cinnet			ROCKVI	rial	J 14114 20	
	Registra	ar	32. registrate signature of the state of the	, K	Goarde				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Max 9:15 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 091 timore The Johns Hospita Hopkins If Under 24 Hrs. If Under 1 Year last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Min 1 ☐ M 2 💢 F 244-80-7247 Yrs. 12-29-1949 N.C. Director Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ehow permit. Pages 1 and 2 should be filled within 72 hours atter death with the Marylar Department of Health and Mental Hygiens. Influent 23s or 28e-1 ehov Importent: If team 27 is marked other than "natural; or litema 23s or 28e-1 ehov any injury or other treumatic event, If a Medical Exercities must be notified at 1. Yes 2 □ No Balto Be Completed by Funeral Director N/A Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 4111 W. Coldspring Lane 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ♣ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) M. T. A. Police 2 years 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Geneva Blackwell Clarence Pettiford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Western Wind Circle Balto, Md 21244 Dominique Thorpe - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/11/2005 Catonsville, Md ' 4 □Donation 5 □ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee March F/H West 22. Name and Address of Facility hompson 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Opset and Death Part1. Inter the disease, or complications that caused the death, shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai attending p IF FEMALE: 23b. Was decedent progrant in the past 12 pronths? 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. by 2×100 3 Probably 1 TYes 4 MUnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No Hospital: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Certification: 5 Pending investigation 1 Natural death. 1 TYes 2 No 2 Accident within 24 hours after deat To the Funeret Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stated and title of certifier 29c. License number 29b. Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

600 North

Wolfe

eted cause of death (Item 23a) (Type, Print)

gistrar's Signature

			1 - For State Registrar	State of I	Marylar		artment of H rtificate of		nd Menta	l Hygier	2000	15936
	Physic		1. Decedent's Name <i>(First, Middle, L</i> Ruth Elizabeth T							of Death	Pays Year	3. Time of Death 2:45 P M
	/Medi Examir		4a. Facility Name (If not institution, g 5206 Benson Ave		er)		4b. City, Town, o Arbutus	r Location of			4c. County of Deat Baltimor	h
	Funeral Director		5. Social Security Number 219-18-6885 Usual Residence of Decedent	Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. 80	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		of Birth hth Day, Yea 05-192	9. Birth	hplace (State or Foreign untry) y Land
	yland how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	e Mar Ba-f s	Director	MD Baltimo	re	A	rbutus						1 ☐ Yes 2 Ho
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	untry?
	leath ns 23	Funeral	5206 Benson Ave	12. Was Decede	nt Ever in U	IS 13 1	21227 Was Decedent of H	ionania Origin	o2 (Cooolis Van		ited Stat	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumetic event, if a Madical Exaculture is use the notified at anone.	by Fun	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 [If Yes, Give Year or Date	is? XNo	1	f Yes, specify Cuba	Specify:	Puerto Rican, e	ic.)	Black, White	
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12	within ene. then '	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. L	DO NOT use retired	()	n woming			
2 2	illed Hygid other ent, II	a)	17. Father's Name (First, Middle, Las	t)		Homem	aker	18. Mother's	s Name (First, M		on Home	
Maryland	Wenta Wenta wrked	To B	William George F	ritz					ian Est		•	
nan)	2 sho and l is me		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number	or Rural Route I	Vumber, City	or Town, State, Z	ip Code)
	1 and Health em 27 ther ti		Nancy L. Yospa /	daughter	20h E	1208	Elmridge sition (Name of	Ave]	Baltimo:		ryland 2	
T O	Pages nent of I snt: If its ury or o		1 ★ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	Removal from Sta		cemetery, cren	ark Cemet	e) cerv 5.			Location - City or 1 .timore, 1	
Baltimore,	permit. F Departme Importer any injur		21. Sign it re of Funeral 2 rvice Lice	1	000	22	. Name and Addres	s of Facility	Ambros	Fune	ral Home	, Inc.
r			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caus	ed the deat	h. Do not ente	328 Sulph or the mode of dvin-	ur Spi u. such as ca	ring Rd	Arbut	us, Mary	Land 21227 Approximate
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BOX	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	I death 3 🗌	Ectopic pregnancy				23d. Date of deliv	ery Day Year
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DIVISION	after dea after dea Director d in by the	ertification	3 Suicide 6 Could not be determined	e 28e. Place of I	njury - At ho etc. (Specify	ome, farm, stre	et, factory, office		28f. Locat City of	ion (Street a r Town, Stat	nd Number or Rura (e)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one) 1 Certifying Pl	ysician: To the bes niner: On the basis and manners	or examinat	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and p inion, death o	lace, and due to	the cause(sime, date an	s) and manner as s id place, and due to	tated. the cause(s)
	To th Withir To th comp.	Me	29b. Signature and title of certifier	1- 1			29c. License	number		29d. Da	ate signed (Month,	Day, Year)
			Edment V	VICaval			D34	445 V		m	ay 9th 2	2005
	10		30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	rint) Flow &	100	Cotm	sv.lle	512 CH	227
	Stat Registra	_	31. Date filed (Month, Day, Year) MAY 1 1 7 11		trar's Signat	lure Acres	Es.					

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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	1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of Marylan	-	artment of He tificate of De			Reg. No.2 () ()5 15	93-
Physician /Medical Examiner	James Evans Trotte	r street and number)	AL	4b. City, Town, or Lo			Day	Year 3. Time of 1°3 0	OM
Funeral Director	5. Social Security Number 6. Se 214-40-6759 Usual Residence of Decedent	ZM 2□F 61	Yrs.	If Under 1 Year II Months Days	f Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 05/18		9. Birthplace (State of Country) D	or Foreign
with the Maryland or 28a-f show be notified at	MD Baltimor 10e. Street and Number		y, Town or Loo	ation 10f. Zip Code			10g. Citizen of W		ity Limits
urs after death verified to the standard of th	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 Mo If Yes, Give Year or Dates:	If	21218 Vas Decedent of Hisp. Yes, specify Cuban, □ Yes 2☑ No	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		American Indian, White, etc.	
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2 should be fill and Mental H Is marked oth aumatic sven	17. Father's Name (First, Middle, Last)		19b. Mailin		Edith Fl	orence E			
Health Health tam 27 othar tu	Donna Trotter 20a. Method of Disposition 1	emoval from State	lace of Disposemetery, crem	Nicholas A ition (Name of atory or other place) e Cremator		Date May 12	20c. Location - 0	.206 City or Town, State	nd
permit. Pages Department of Important: If i any injury or o	21. Signature of Funeral Service/Licens		86 22. Cr	Name and Address of emation and 17 Green Pa	f Facility d Funera	l Altern		, Maryland	2121
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is certificate has been si director, page 2 should To Be Completed	25. Was case referred to medical					1 ☐ Yes	sy primed? de 2 No 1 [ere autopsy findings ior to completion of c ath? Yes 2 No	available ause of
± 5 €	examiner? 1	The state of the s	ER/Outpatient 28b. Time of Injury	3 □ DOA Other: 28c. Injury at Work?	4 Nursing Ho	h <i>(Check only or</i> me 5 ☐ Resid 28d. Describe h	ence 6 Other	(Specify) d	
which 24 hours after death. To the Funaral Director: After th completely filled in by the funeral Medical Certification; 7	3 Suicide 4 Homicide Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	')		data and at	City or Tow	n, State)	r or Rural Route Num	ber,
within 24 hours a To the Funaral I completely filled	(Check only one) 29b. Signature and title of certifier	ician: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my opinion	on, death occuri	ed at the time, o	date and place, and 29d. Date signed	ner as stated. Indidue to the cause(s (Month, Day, Year)	τ
1	30. Name and address of person who co	N BLAD' BY	altimo	Print) SURAB	HI AC	IARWA			
State Registrar	31. Date filed (Month Day Year) 2005	22. Registrar's Signat	ure gos	W		<u> </u>			

			1 - State of Maryland / Dep	artment of Health and Mertificate of Death		ene 005	15938
П	Dhoratal		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Steve Vaonakis		May	5 2005	4:18 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	uth
			Laurel Regional Hospital	Laurel		Prince G	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday XXM 2 F 76 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	rear) C	thplace (State or Foreign ountry)
-	Director		Usual Residence of Decedent		July 7,	1928 Wes	t Virginia
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mar.	ţo	MD Prince George's Laure	1			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	ountry?
	th wil		501 Main Street, #121	20707		USA	
	ams erm	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	
õ	or It		1 Never Married 2 Married 1 MYes 2 No	1 ☐ Yes 2 X No Specify:	7 110411, 010.7	Specify: Wh	
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or Itams 23a or 28a-f show Ita Medical Evartiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:	<u> </u>		Specify. WI	ite
ភ្ជ	"nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation o kind of work done during most of work DO NOT use retired)	king	Sb. Kind of Business	/Industry
7	withii ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	rts Agent		Horse Rac	ina
ם ס	filed Hygi other	Ö	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		1119
ana	ld be ental ked c	ToB	Pete Vaonakis		Korstos	,	
<u></u>	12 should be filed within h and Mental Hygiene. 7 Is marked other than " Iraumatic event, the Me			ing Address (Street and Number or Rui		City or Town, State,	Zip Code)
	alth a		Mary Dell Vaonakis/Wife 501	Main Street, #121,	. Laurel.	MD 2070	7
ē,	of Hear		20a. Method of Disposition 20b. Place of Disp		1944	Oc. Location - City or	
altimo	Page nent contract iny or		I E Bondi E E Bondination o Entantoval nom otato	l l	/2005	Odenton,	MD
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, it a Macifical Exercitor must be rediffed an once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Do	onaldson	Funeral H	ome, P.A.
מ	80 E 29		Carulla DO M01103	313 Talbott Avenu			0707
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
. 1	Pnysician	E 19	Immediate Cause (Final disease or condition Pneumonia				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Lxaimilei		Sequentially list conditions, b. Parkinsonis	m			
/	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	be executed ician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Hypertensio Due to (or as a consequence of):	П			
8/60	ficate be executed physician and s the burial-transit	dlcal E					
200	ficate g physics ts the	edlo	d				
XOD	w requires that the death certific been signed by the attending p should be detached for use as	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
	death e atten	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
5	at the by th tache	hys	9 ☐ Unknown 9☐ Unknown				
'n	The law requires that the ate has been signed by the page 2 should be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
	equire ien si ould l	ted	Altered Mental Status		1 🗌 Yes	2 4 No 3 □ P	robably 4 Unknown
mecoras,	E S CS	ompleted			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		Con			performe	d? death?	2 □ No
N I I I	tanding Physician: leath. tor: After this certific: the funeral director,	Be	25. Was case referred to medical examiner?		h (Check only one)		
=	d sigh	7	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of Death			ce 6 □Other (Spe	icify)
	ding F h. After funera	lon	1 Natural 5 Pending (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
UNISION	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined elemined 28e. Place of Injury - At home, farm, st		28f Location /Stre	et and Number or R	ural Pouta Number
2	after after Direct	Certification:	4 Homicide determined 288. Place of injury: At nome, farm, si building, etc. (Specify)	reet, factory, office	City or Town,		urai riodio reditibor.
	pspite hours ineral y filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cau	se(s) and manner as	s stated.
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edical	one) 2 Medicel Examiner: On the basis of examination and/or if	vestigation, in my opinion, death occur	red at the time, date	and place, and due	e to the cause(s)
	To T Com	Σ	29b. Signature and title of certifier	29c. License number		I. Date signed (Mont	
			> 18they to MD. Attending.	D42580	I I	May 5, 200	J5
	37		30. Name and address of person who completed cause of death (Item 23a) (Type Parmjit S. Aujla, MD 5632 Ann	Print) apolis Road, #13,	Bladensb	urg, MD	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 1 2005 32 Registrar's Signature	and the same of th			

7-7-1928.

STEVE, VACUALUS

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Sally Ann Voreacos 9:10 PM M /Medical 2005 May 8, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗷 F Director 76 279-26-9630 02/16/1929 ÒН Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ir items 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2103 Chapelwood Court 21093 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Maryland 21215-0036 ŏ Specify: White 1 Yes 2 No ð Specify: 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiene.
7 Is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Hospital Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Ambrose Cahill Laura Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Paul H. Voreacos 2103 Chapelwood Court Lutherville Timonium, MD 210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State May 10 ' 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00986 Hali Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bronchio Alreolar cell Carcinoma Physician disease or condition resulting in death) Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consistuence of Examine burial-transit resulting in death) Last Due to (or as a consequence of). 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Vital 1 Yes 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 Anthony mo 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 6 BMC 6701 31. Date filed (Month. 32. Régistrar's Signature State Registrar

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_		1 - For State Registrar	State of Ma	aryland /	-	artmen <i>tificat</i>			and M		giene Reg:No.	105	15940
Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, La tasan L. L. 4a. Fecility Name (If not institution, giv NOTHWEST	L. He gr., e street and number)	LENT	ER			Location o		2. Date of Dea Month	Day > 2.0	Year	
Funeral Director				(In yrs. last b		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da) 2-25-	h y, Year)		thplace (State or Fore ountry) Md
e Marylend 8e-f show Lifted af	ctor	10a. State 10b. County Md	N/A	10c. City, To		cation							10d. Inside City Lim 1 √ Yes 2 ☐ I
be filed within 72 hours after death with the Marylend ital hygiene. Ital hygiene. In insturel; or Items 23a or 28e-f show event, the Modical Examinating the multiput at	sted by Funeral Director	10e. Street and Number 6219 Liberty He: 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Types 2 N If Yes, Give Year or Dates:	ver in U.S.	a. Deced	Vas Deced f Yes, spec l ☐ Yes	1207 ent of His ify Cubar	Specify:		cify Yes or No- Rican, etc.)	- 14 - 5	S A 4. Race - Am Black, Whi 6. Pecify: d of Business	erican Indian, te, etc. Black
be filed tal Hygi d other	To Be Completed	(Specify only highest grade 17. Father's Name (First, Middle, Last) Leroy T. White	College (1-4or 5-	. 1	life. L	kind of wor DO NOT us rity	e retired) Guar	d 18. Mothe		(First, Middle,			Maryland
12 s h ar 7 is freu	Ė	19a. Informant's Name/Relationship (Carolyn White — 20a. Method of Disposition 1 ➡ Burial 2 □ Cremation 3 □	Wife		219	Libe	rty l	nd Numbe Heigh	r or Rura	Route Numbe	Bal 20c. Loca	to, Md	21207 Town, State
permit. Pages 1 and Department of Healt importent: If Item 2 any injury or other once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen ↑	<i>(</i>)	Garri		. Name and	d Address	of Facility	Mar	ch F/H nue Ba	Wes		
Cate be executed / Medical Examiner (the buriat-transit in the	dical Examiner	23a. Parth. Enter the disease, or com, show, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	a	e. consequence consequence	of):	er the mode	a of dying	, such as d	cardiac oi	respiratory an	rest,		Approximate Interval Between Onset and Death
the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal deatl		Ectopic pre Other (spe					23	d. Date of dei Month	ivery Day Year
The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant conditions of		t not resulting						1 🗆 Y	es 2.2	No 3□Pr	o the cause of death?
	Se Completed	25. Was case referred to medical						26. Place	of Death	24a. Was a autops perform 12 Yes	sy med? 2 No	24b. Were at prior to death?	itopsy findings availa completion of cause 22 No
ding Phys h. After this funeral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day		utpatient Time of Injury		Other Ic. Injury a Work?	: 4 □ Nur	sing Hom	e 5 Reside	ence 6[cify)
spitel or ours afte erei Dir filled in I		3 Suicide 4 Homicide 6 Could not be determined	building, etc.	(Specify)	e. death	occurred a	t the time	, date and	place, a	City or Town	n, State)	nd manner as	ral Route Number,
To the Hos within 24 hr. To the Fun completely	Medical	(Check only one) 2 Medical Exemple 29b. Signature and title of certifier	iner: On the basis of and manner state	examination ar	nd/or inv	estigation,	License	nion, death	occurre	d at the time, d	late and pl	lace, and due	to the cause(s)
To the within 2 To the complet													i, Day, Tear)

			1 - For State Registrar	State of Maryl		artment of Fertificate of		Mental Hy	giene 0	5 1	5941
1	Physici /Medi		1. Decedent's Name (First, Middle, Last) Doris E. Warren					2. Date of De		Year 005	3. Time of Death
	Examir		4a Facility Name (If not institution, give s. 5. Social Security Number 6. Sex	Eathco	CE yrs. last birthday	ROLL If Under 1 Year	r Location of Dea	•	4c. County n/a	9. Birthpla	ce (State or Foreign
Į.	Director		224-22-8691 1 Usual Residence of Decedent	M 2 X F	83 Yrs.	Months Days	Hours Min	Dec 2	th ay, Year 3, 1921	Nor	th Carolina
	Marylan a-t show	ctor	10a. State 10b. County Maryland Baltimo		City, Town or Latons V					100	d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Dire	10e. Street and Number 709 Maiden Choic	e Lane		10f. Zip Code 21228	3		10g. Citizen of V		•
036	be filed within 72 hours after death with the Maryland lat Hygiene. dother than "natural", or items 23a or 28a-1 show event, tre Medical Examirer must be redified at	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.))- 14. Rac	e - Americar ck, White, et	n Indian,
9500-51212	d within 72 ho jiene. r than "natur I're Medical i	Completed	15. Decedent's Educ (Specify only highest grade) 1 Elementary/Secondary (0-12) 0	ation completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire memaker	nation during most of wo	orking	16b. Kind of Bu		stry
/land	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last) unknown				18. Mother's Na Nettie	me (First, Middle Eller	, Maiden Sumarr	18)	
Mar.	nd 2 allth ar allth ar 27 is		19a. Informant's Name/Relationship (Typ Judy Shilling –			ing Address (Street					
saltimore,	Pages 1 a nent of Hea int: it item iry or othe		20a. Method of Disposition 1	moval from State	ly Trinit	osition (Name of matory or other place y Russian emetery	^{сө)} Мау 200	Date 12,	20c. Location · Elkri		
Balt	permit, Pagi Depertment Important: I any injury o		21. Signature of Funeral Service Ligense		2	2. Name and Addre	ss of FacilityHu	bbard H	runeral	Home	
	Physician		23a. Part1. Enter the disease, or implication shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	100		iter the mode of dyir	ng, such as cardia		rrest,	A Ir	Approximate Interval Between Onset and Death
8760,	/Medical Examiner bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	C OM sequence of):	twetve				e Y	eves
O. Box 6	the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Dat Mor	e of delivery	ay Year
ras, r	requires that een signed b hould be deta	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the t	underlying cause giv	en in Part I.		obacco use contr		cause of death?
al Record	The law ate has b	Completed						24a. Was autor perfo 1 🗆 Yes	ormed?	rior to comp leath?	y findings available eletion of cause of
on or vital	ding Phys	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	er: 4 □ Nursing I	ath (Check only of Home 5 Residence 1 28d. Describe I			
DIVISION	al or Attend efter death Diractor: d in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office	3 (57	28f. Location (: City or Tox	Street and Number vn, State)	er or Rural F	loute Number,
	To the Hospital or At within 24 hours efter o To the Funeral Dirac completely filled in by	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my er: On the basis of exan and manner stated.	knowledge, dea nination and/or in	th occurred at the tire	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as state	e cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number	ž	29d. Date signed		
	10				Item 23a) (Type	Print)	timore	Mari	land	•	
	Sta Regišti		30. Name and address of person who con Susan Esposito 31. Date filed (Month, Day, Year) MAY 11	32. Registra S 2005	ignature J.	parte					

		F	State of Man		artment of H			_	
		1 - For State Registrar			rtificate of L			2005	15942
Physic	an	Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	Laura Eleanore						10 2005	
Examir	ner	4a. Facility Name (If not institution, g				Location of Death		4c. County of Dea	ath
Funeral		2010 Hillcroft 5. Social Security Number 6		n yrs. last birthday)	Forest If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Harfo	
Director		218-09-3920	1□M 2XF	36 Yrs.	Months Days	Hours Min.	(Month, Day, Y		rthplace (State or Foreign ountry)
and		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ecation				10d. Inside City Limits
Maryla feho	į								1 Yes 2X No
15-0036 72 hours after death with the Maryland 72 hours after death with the Maryland 7 heturel; or items 23s or 28s-1 show 6 cel Examiner must be malified at	Director	MD Harfo 10e. Street and Number	ra	Forest	10f. Zip Code		10g	. Citizen of What C	ountry?
th wit	ai D	2010 Hillcroft	Drive		21050			U.S.A.	
er dea	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XXNo If Yes, Give Year or Dates:		_	Specify:		Specify:	
2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	16	b. Kind of Business	nite s/Industry
21215-0036 d within 72 hours af giene. ar then "natural, or	Completed	(Specify only highest (Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work.)	ing		,
		4	-13	Но	memaking			Own Hor	ie
E dala	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	e (First, Middle, Ma	iden Surname)	
aryla 2 should I and Menl is market	2	George Hoffman 19a. Informant's Name/Relationship) (Type, Print)	19b. Mailir	ng Address (Street a	Mary Bo		ity or Town State	Zin Code)
		Thelma Grazian							yland 21050
altimore, mit. Pages 1 ar partment of Hea portant: If item y njury or otha	1 6	20a. Method of Disposition 1 Burial 2 □ Cremation 3	_	20b. Place of Dispo	sition (Name of natory or other place	Θ)		c. Location - City or	
Pages Pages ment of ant: if it		'4 □Donation 5 □Other (Spe	LITTOTION STATE		Memorial	1	3/2005 Fa	allston.	Marvland
Baltimol permit. Pages Department of Important: If it any njury or o		21. Signature of Funeral Service Lic	ensee	22	2. Name and Addres				al Home, P.A
		23a. Part 1. Enter the disease, or co	and and an an an an an an an an an an an an an						land 21087
Dhartsian		shock, or heart failure. List or Immediate Cause (Final	ity one cause on each line.	1 .	/ /	- 1		,	Approximate Interval Between Ogset and Death
Physician /Medical		disease or condition resulting in death)	a On 91 Due to (or as a co		lart	1-41/40	(Iweik
Examiner		Conventially list and divine	Rena	1 Fai	lune				4 4140
√ p =	iner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that interest and account of the cause	Due to (or as a co	oneequands of):					
60, Constitution and Sicien and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
760, e be ex sicien e buria	icai E		230 10 (0) 43 4 3	5/100 qualitoc 01).					
			0.						
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of de	livery
at the deal by the att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim		Other (specify)			Month	Day Year
P.O hat the od by th detache		Part II. Other significant conditions	s contributing to death but o	ot resulting in the u	nderhing cause auro	on in Dart I	22a Did tobac	100 uso contribute t	o the cause of death?
ecords, P law requires that as been signed b	d by	,	o dodan barri	or resulting in the di	nderlying cause give	on in Fait i.			robabiy 4 Unknown
w requ	lete						24a. Was an		utopsy findings available
The lav	Completed						autopsy performed	prior to death?	completion of cause of
	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 ☐	No 1□Yes	s 2 No
Of VI	10 E	1 ☐ Yes 25 No	Hospital: 1 Inpatient	2 ER/Outpatier	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Residenc	e 6 Other (Spe	ecity)
On C ding P h. After t funera	ion:	27. Magner of Sath 1- Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	28c. Injury Work	at	28d. Describe how	injury occurred	
DIVISION OF N or Attending Physeler death. i Director: After this d in by the funeral d	licat	2 Accident investigat 3 Suicide 6 Could no	t be	- At home larm str		/es 2 □No	281. Location (Stree	at and Number or P	ural Pauta Number
DIV Block	Certification:	4 Homicide determine	building, etc. (Specily)	cot, factory, office		City or Town, S	State)	arai Houte Number,
pspite hours unerally fille		29a. Certifier Certifying	Physician: To the best of m	ny knowledge, death	occurred at the tim	e, date and place,	and due to the caus	e(s) and manner a	s stated.
Division of Vita vertical by the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		aminer: On the basis of ex and manner stated	amination and/or in					
To To	2	29b. Signature and title of certifier	15		29c. License			Date signed (Mont	
		701- 20			D 3	4012	14	ay 10,	2005
10		30. Name and address of person what Scoth	to completed cause of death	1 1 1	Print)	Bul	1 1	Mana la	2005
Sta	ate	31. Date filed (Month, Day, Year) MAY 1 1 2005	32. Registrar's		N. I alai	17/	110	10119 141	
Regist	rar	MINI T T CONP	Allowed Di	perke	9				

			1 - State of Ma		artment of Health and rtificate of Death		giene	15010
			Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Physici		Richard Ne	al Wilbur	n, Sr.	Month May	6, 2005	10:57 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	
			Holy Cross Hospital		Silver Spring		Montgomer	У
П	Funeral		7.2	(In yrs. last birthday)	If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthp	lace (State or Foreign
١.	Director		212-38-6528 1 M 2 □ F Usual Residence of Decedent	65 Yrs.		March 6,	, 1940 Mary	land
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Many Hed	to	Maryland Montgomery	Silver S	pring			1 ☐ Yes 2 🎇 No
	r 28a	Directo	10e. Street and Number		10f. Zip Code	1	10g. Citizen of What Cour	itry?
	23a c	aiD	12208 Selfridge Road		20906		United Stat	es
	r dea	Funerai	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
9	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Miles 1 ☐ Yes 2 ☐ Nover Miles 2 ☐ Nover Married 2 ☐ Nover Mar	lo	1 ☐ Yes 2 ☑ No Specify:			nite
215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or event, the Madical Examiner must be notified at	ed b	3 Widowed 4 Divorced Year or Dates:	16a Decey	dent's Usual Occupation		16b. Kind of Business/Inc	
Š	n "nat	piet	(Specify only highest grade completed)	(Give	kind of work done during most of wo DO NOT use retired)	orking	16b. King of business/inc	lustry
7	d withln giene. rr than "I	Completed	Elementary/Secondary (0-12) College (1-4or 5-	Auto	Mechanic		Automobile	Repair
<u> </u>	e filed at Hygid other vent,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, I		
yland	ould be Mental arked o	10	Norman Wilburn		Hazel	Marie Cus	ster	
Mar	2 should be and Mental la marked c		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F			•
e o	l and lealth im 27 her ti		Linda L. Wilburn / Wife		Selfridge Road,			
saitimore,	if its		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State		sition (Name of natory or other place) May	10,	20c. Location - City or To	
	it. Partmer rtant rtant njury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee				Bethesda, Ma	
n n	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		and the Consist	M01305 30	, Name and Address of Facility bert A. Pumphrey Fur U west Montgomery Av	meral Home/ enue, kockv	Rockville, Inc	20850-2805
			23a. Part1. Env.r the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Be, veen
	Physician		Immediate Cause (Final disease or condition Respi	ratory Fai	lure			Onset and Deatri
	/Medical Examiner			a consequence of):				
		-	Sequentially list conditions D	ic Obstruc	tive Pulmonary D	isease		
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	reorinaquarica ory				
	axecu and al-tra	Examiner	that initiated events c.	a consequence of):				
5/60,	certificate be executed ding physician and use as the burial-transit	cai	d					
ŏ	rtifical ng phy as th	Q	IS SEXUE					
X Q	that the death certific ed by the attending p detached for use as	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the latest past 12 months?		Ectopic pregnancy		23d. Date of delive	*
	the attenthed for u	/sicl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)		Month	Day Year
7	that the side by detac	٥	Part II. Other significant conditions contributing to death but	ut not resulting in the ur	iderlying cause given in Part I	23e Did tob	bacco use contribute to th	e cause of death?
S S	iw requires that the s been signed by th should be detache	d by	· ·	3	, ·· g g	1 🔀 Y€	es 2□No 3□Prob	ably 4 □Unknown
	> 0 0	ompleted				24a. Wasa	n 24h Were autor	osy findings available
Į.	e ta has	ш				autops perform	y prior to con	npletion of cause of
NI GI	iclan: Th certificate rector, pag	e C	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ath (Check only on		2 No
	d is	O B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatier	nt 2 ER/Outpatien	Ort	-	ence 6 ☐Other (Specify)
0	D D D D	n: T	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day	y 28b. Time of Injury			ow injury occurred	
20	tending death. tor: All the fu	cation:	2 Accident investigation		M 1 Yes 2 No			
DIVISION	ter c lrec lrec	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or Rurai n, State)	Route Number,
_	pital ours a eral E	0	29a. Certifier 1K Certifying Physician: To the best of	4		1		
	To the Hospital c within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or inv	restigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as sta ate and place, and due to	the cause(s)
	To T To I	2	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month, L	lay, Year)
0	11		> Sey (UM -		D36252		May 6, 2005	
1)		30. Name and address of person who completed cause of de Steven T. Kariya, M.D. 115		Print) a Avenue, #515, W	heaton. N	Maryland 200	02
	Sta	tė	31. Date filed (Month, Day, Year) 32. Registra	r's Signature				
	Registr	ar	MAY 1 1 2003	Elecus St.	Goste			

Please Type or Print in Black Indelible Ink. Fesure All Copies Are Legible.

State of Maryland / Department of Head and Mental Hygiene 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year WATSON ER BER STE WART 11: ZUA M /Medical 2005 4a. Facility Name (If not institution, give street and number) BRECC. 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Blud Baltimore 3800 Kaven If Under 24 Hrs. Baltimore Co. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**₽**M 2□F Min Yrs Director 200-20-8604 May 2, 1928 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits **ehow** rthan "natural", or Items 23a or 28a-f ehov Tre Medical Evantrer must be notified at Funeral Director 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1959 Dineen Drive 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify. 3 Widowed 4 Divorced Year or Dates: 1945-49 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) 11 Years Tin Roller es 1 and 2 should be filed to of Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other in other traumatic event, in Steel Industry marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Walter Scott Watson Mary Freda John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elizabeth A. Watson (Wife) 1959 Dineen Drive Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ö N Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department or Important: If any Injury or 4 □Donation 5 Other (Specify) Meadowridge Mem. Park Cem. 5/9/1005 Dorsey, Maryland 21. Signature of neral Service 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) burial-transit that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? ension case referred to medical Vital 2 No 1 Yes Yes Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther. Certification: To Nursing Home 5 Residence 6 Other (Specify) this Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours at To the Funeral C completely filled i filled to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056508 MO LIANGRANG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State of Maryland / Dep	partment of Health and I Pertificate of Death	Mental Hy	/giene 005	15945
Physic /Med		Decedent's Name (First, Middle, Last) Helen M. Wong		2. Date of De Month May	Day Year 6, 2005	3. Time of Death 10:15 A ^M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	
Funeral		Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Bethesda // If Under 1 Year If Under 24 Hrs.	8. Date of Bi	Montgome	
Director		578-34-4359 1□M 2\ F 91 Yrs.	Months Days Hours Min.	May 4,	ay, Year) 4 Col	thplace (State or Foreign ountry) orado
yiand yiand		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or I	cocation			10d. Inside City Limits
e Mar	ctor	Maryland Montgomery Bethesd	a			1 ☐ Yes 2 🙀 No
with the a or 20	Dire	10e. Street and Number 6510 Democracy Blvd.	10f. Zip Code		10g. Citizen of What Co	
death ms 23	Funeral Director		20817 Was Decedent of Hispanic Origin? (S)	pecify Yes or N	United Stat	
ING 21213-UU36 be filed within 72 hours after death with the Maryland ttal Hygiene. dothar than "natural", or items 23a or 28a-f show event, it a Madical Exeminational to retified at	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	o Rican, etc.)	Black, Whit	e, etc.
within 72 h ene. then "netu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business	/Industry
Z1Z Z1Z d with giene.	Comp	College (1-40r5+)	tal Assistant		Dental Off	ice
Maryland 2 d 2 should be filed in the and Mental Hygis is marked other traumatic event, II	Be	17. Father's Name (First, Middle, Last)	110000		e, Maiden Sumame)	
aryland Z should be filed and Mental Hygi marked other umatic event, I	2	Jose Montoya 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Guadali ling Address (Street and Number or Ru	upe Sena		Zio Oo da l
C = 0 L			Democracy Blvd.,			
Saltimore, permit. Pages 1 ar Department of Hea mportant: if Itam injury or other once.		Exposition 2 Crestilation 3 Heritoval from State	ematory or other place) May	Date 9,	20c. Location - City or	
Baltimore permit. Pages 1 Department of H Important: if Ital any injury or ott			aven Cemetery 2005		Silver Spring	
Per Per Bany		MOIZOT RO	2. Name and Address of Facility Obert A. Pumphrey Fune 57 Wisconsin Avenue, 1	eral Home Bethesda,	/Bethesda-Chev Marvland 2081	y Chase, Inc. [4-350]
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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Examiner		(21 ral no m 7	ing orionso			
ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
60, be executed ician and burial-transit	Еха	that initiated events c. The sulting in death) Last Due to (or as a consequence of):				
cate cate the the	dicai	d				
COIGS, P.O. BOX by requires that the death certification been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moors? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3	□Ectopic pregnancy		23d. Date of deli	- /
tithe de	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
ecords, Priaw requires that as been signed be 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	tobacco use contribute to	the cause of death?
RECOTOS he faw requires has been sign	eted	Riving 14/1240CC				obably 4 dinknown
he la	Completed				psy prior to o prmed? death?	topsy findings available completion of cause of
ysician: T	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 ☐ Yes th (Check only o		2 No
5 4 E	. To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			dence 6 Other (Spec	cify)
	ation	1 Swatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	zod. Describe	how injury occurred	
DIVISION C all or Attanding F s after death. I Director: After d in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (City or To	Street and Number or Ru wn, State)	ral Route Number,
To the Hospital or Attant within 24 hours after deall To the Funaral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal and manner stated and manner stated.	th occurred at the time, date and place, overstigation, in my opinion, death occur	and due to the	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	
2 10		held m	52774		MAY 7	2005
11.		30. Name and address of person who completed cause of death (Item 23a) (Type Suburl BN (DSPIN BC)	4	M.D. 86 20814	600 Old George	town Road
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	THOA MD 2	20014		
Regist		MAY 1 1 2005 Seem &	local s			
DHMH 17 Rev 1/2	:001	ORIGIN	AL			

			For State	-	epartment of Health and I Certificate of Death		/ 11 11 15	15916
			Registrar 1. Decedent's Name (First, Middle, Last)	11/ 11	ertificate of Death	2. Date of Death		3. Time of Death
	Physicia /Medic		James	Walters		May 6,	2005	1635 M
	Examin	er	4a. Fecility Name (If not institution, give	street and number) Apt	4b. City, Town, or Location of Death Baltimore	P	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 15	7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Yes	122 No	hplace (State or Foreign
	rryland rhow		10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	the Ma 28a-f s	Funeral Director	Nacyland NA 10e. Street and Number	Bal	timore 101. Zip Code	100	Citizen of What Co	1 XYes 2 No
	h with	al Dir	1200 Hallins	St. 221	21223	log.	1151	4
	tems term	uner	T. Wantar States	Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
036	urs afte	by	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 N Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: R	lack
5-0	n 72 ho	eted	15. Decedent's Edu (Specify only highest grade	completed) (C	ecedent's Usual Occupation Give kind of work done during most of work	rking 16b.	Kind of Business	Industry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ont, the Medical Examinat must be politied at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	te. DO NOT use retired)		Const	ruction
	should be filed withir nd Mental Hygiene. marked other than imatic event, the Me	BeC	17. Father's Name (First, Middle, Last)	1-13 10/11		ne (First, Middle, Maid	en Sumame)	
Maryland	should and Men le marke sumatic	2	Thoney Fo	anklin Walt po, Print) Friend 19b. N	Aailing Address (Street and Number or H	ITAL Route Number, Cit	v or Town, State.	Zip Code)
	1 and 2 s Health ar sem 27 le		Mrs. Alpha P	andy 85	27 N. Arlington	Ave 603	Batto	Md. 21217
Jore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F	emoval from State	isposition (Name of crematory or other place)	Date 20c.	Location - City or	Town, State
altimore,	그 문 뿐 글	1	* 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service License	Garn	32. Name and Address of Facility	C	vings 11	ins, Na.
ä	Depa Impo any ir	10 1	Joseph	L. Russ	Joseph L. Kuss 1 2222 W. North Ave.		tome P. d. 2121	,
L	MICHAEL SE		23a. Parti. Enter the disease, or compleshoot, or heart failure. List only of Immediate Cause (Final	cations that caused the death. Do not ne cause on each live.	t enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of				2 day
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	uted d ansit	miner	Cause (Disease or injury that initiated events	Due to (or as a consequence of)	0			
90,	ficate be executed physician and s the burial-transit	i Exami	resulting in death) Last	Due to (or as a consequence of)	:			
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.O. Box	it the death certific by the attending p tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	ivery Day Year
<u>α</u>	de de	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc		the cause of death?
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Rec	he la e has	ompieted				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ital		Be Co	25. Was case referred to medical examiner?			1 ☐ Yes 🙎 ☐	No To res	2 No
of \	Phys r this ral di	은	1 ☐ Yes 25 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp. 28a. Date of Injury 28b. Tim		lome Residence		cify)
点	Attending Phr r death. ector: After thi by the funeral.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju	28c. Injury at Work? M 1 Yes 2 No			
Division of Vital	l or Atten after deatl Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by It		29a. Certifier Certifying Phy	sicien: To the best of my knowledge, o	death occurred at the time, date and place	e, and due to the cause	(s) and manner a:	s stated.
	the Ho hin 24 the Fu	Medical	one)	and manner stated.	or investigation, in my opinion, death occu			
}	To wit		29b. Signature and title of certifier		D 2046	250.	Date signed (Mont	Jaj, idaij
1	1		30. Name and address of person who co	empleted cause of death (Item 23a) (Ty	29c. License number D S 7445 ype, Print) p M and y T y L		1 110	
	Sta	te	31. Date filed (Month, Day, Year)	320 Registrar's Signature	market Com La	212	27	•
	Registr		MAY	I I ZUUS JOHN	~ 17			

		•	For State Registrar	State of M	Maryland / I	•	tment of H		and Me		ene 005	5 159	947
			Decedent's Name (First, Middle	e, Last)					2.	Date of Death		3. Time	of Death
	Physici /Medic		Maxine Aust	in					A	pril 26	, 2005	5:20	РМ
	Examin		4a. Facility Name (If not institution	n, give street and number	ar)	4	b. City, Town, or	Location of	of Death		4c. County of £	Death	
			Citizens Nursi				Frederi				Frede		
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. last bi		If Under 1 Year Months Days	If Under :	Min.	Date of Birth (Month, Day,)	(ear) 9.	Birthplace (State Country)	or Foreign
	Director		294-20-2005 Usual Residence of Decedent		78	113.			00	ct. 29,	1926	Ohio	
	/and		10a. State 10b. County		10c. City, Tow	vn or Locat	tion					10d. Inside	City Limits
	Man,	ţ	Maryland Fre	derick		Free	derick					1 ⊠ Ye	s 2 □ No
	72 hours after death with the Maryland natural', or Itame 23a or 28e-f show deat Examiner must be natified at	Funeral Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of Wha	t Country?	
	th will	aic	1001 Carroll Pa	rkway, Apt.	412		2	1701			United	States	
	r dea	nei	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. s?	13. Wa	s Decedent of Hi	spanic Orig	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		American Indian, White, etc.	
36	or li	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1	Yes 2 No	Specify:				White	
8	hour tural		15. Deceden			Deceden	nt's Usual Occupa	tion		1 14	6b. Kind of Busin	occ/Industry	
5	in 72 in "n	Completed	(Specify only highes	st grade completed)		(Give kin	nd of work done d NOT use retired,	luring most)	t of working		D. KING OF BUSIN	essindustry	
212	s within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Fari					Agric	ulture	
פ	be filed within 72 hours after death with the Marylan nat Hygiene. ed other than "natural", or itame 23a or 28e-f show event, the Medical Examiner man be natified at	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (F	irst, Middle, Ma	aiden Sumame)		
<u>lar</u>	uld b Wenta rrked	ToE	Leslie Foster					Mari	ie Sha	rpe			
Maryland 21215-0036	s 1 and 2 should be f Health and Mental is Item 27 is marked or othar treumatic eve		19a. Informant's Name/Relations	hip (Турө, Print)	198	b. Mailing	Address (Street a	and Numbe	er or Rural F	Route Number, (City or Town, Sta	te, Zip Code)	
≥,	of Health of Hem 27 I	1	William Austin	/ Husband					1	_		ck, MD 2	1701
Baltimore,	ges 1 t of H If Ite or otl		20a. Method of Disposition 1 ☐ Burial 2 整 Cremation	3 □Removal from Sta	te 20b. Place o	of Dispositi ery, cremat	on (Name of tory or other place	e) A	pril Date	² 8,	Oc. Location - City	y or Town, State	
Ë	t. Partmen		'4 □Donation 5 □ Other (S		Restha	-	Cremator		200	5 F	rederick	, Maryla	and
Ba	permit. Pages 'Department of P Importent: If Ite any Injury or ot		21. Signature of Funeral Service	Licensee		Res	lame and Addres thaven l	s of Facilit Funer	al Se:	rvices,	Skkot C	Cody P.A MD 2170	i
			23a. Part1. Enter the disease, o	complications that caus	ed the death. Do							Approxim- Interval B	ate
N.	Fnysician		Immediate Cause (Final	only one cause on each	osepes	10						Onset and	d Death
	/Medical		disease or condition resulting in death)		as a confequence							Bu	7.5
	Examiner		Conventially list and discon	h Al	zheime	evs	Disc	me				year	u
	₽ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence							1	
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									- 13
8760,	death certificate be executed e attending physician and od for use as the burial-transit	E	rooming in abani, and	Due to (or	as a consequence	01):							
87	physi the b	Physiclan/Medical		d.									
9 x	death certifica attending pt I for use as t	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy	-72					23d. Date of	deliven	
Вох	atter atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		ctopic pregnancy other (specify)				Month	Day	Year
o.	that the de led by the i	lysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknowr			(-,,,						
О,	res that the igned by th be detache	by PI	Part II. Other significant condition	ons contributing to death	but not resulting i	in the unde	erlying cause give	n in Part I.		23e. Did toba	cco use contribu	te to the cause of	death?
g	- 07 73									1 ☐ Yes	2 No 3	Probably 4	Unknown
000	> 1 0	plet								24a. Was an		e autopsy finding to completion of	
Ä	면 도면	Completed								autopsy performe 1 ☐ Yes 2		:h?	Cause of
Vital Records,	ysicien: This continuity is certificate director, peg	Bec	25. Was case referred to medical examiner?	1				26. Place	of Death (C	Check only one	-		
of V	di S	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 ER/O	utpatient	3□ DOA Othe	or: 🖟 Nu	rsing Home	5 🗌 Residen	ce 6 Other (Specify)	
		 0	27. Manner of Death 1 Natural 5 Pendin	28a. Date of li (Month, i		Time of Injury	28c. Injury Work	:?		d. Describe how	injury occurred		
Sio		cati	2 Accident investig	not be	1-1 - 4-1 - 6			/es 2 □ 1		1			
Division	i di di	Certification;	4 Homicide determ	ined 28e. Place of	Injury - At home, fa etc. <i>(Specify)</i>	arm, street	t, factory, office		281	City or Town,		or Rural Route Nu	mber,
_	To the Hospitel or Al within 24 hours efter of To the Funeral Direc completely filled in by	Ö	29a. Certifier 1 Certifyin	ng Physician: To the be	st of my knowledge	ie, death o	coursed at the tim	e date an	d place, and	due to the car	ISA(s) and manno	er as stated	
	24 h	edical	(Check only 2 Medical one)	Examiner: On the basis	of examination ar	nd/or inves	stigation, in my op	inion, deal	th occurred	at the time, dat	e and place, and	due to the cause	(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie				29c, License				d. Date signed (M		
	^			to			D43	091			4-27-0	5	
	. 7		30. Name and address of person	who completed cause of	f death (Item 23a)		int)	1.1		1	0 1	ch, M	0
	**			Zaidi M	7/)	801	1016	100	ouse.	11/4 1	reden	che 17	ソ
	Sta Registr	_	31. Date filed (Month, Day, Year)	8 2005 32. Re	strar's Signature	i A							
						8							

				epartment of Health and N Certificate of Death		giene ())5	159	48
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ith Day	Year	3. Time of	
	/Media		Harold Aloysius Anderson, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 30	2005 4c. County	of Dooth	6:05	A M
	Examir	ier							
	Funeral		St. Mary's Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)		8. Date of Birtl	Saint	9. Birthp	lace (State o	or Foreign
	Director		215-26-0461 1⊠M 2□F 80 Yr	s. Months Days Hours Min.	(Month, Day December		Cour		
7	2 >		Usual Residence of Decedent						
2	shov	2	10a, State 10b, County 10c, City, Town				1	0d. Inside C	ity Limits 2 ☑ No
2	289-1	Director	Maryland Saint Mary's Mechan	nicsville		(0 0'')			
di di	a or			10f. Zip Code		10g. Citizen of V	Vhat Cour	ntry?	
4	ns 23	Funerai	25655 Baptist Church Road 11. Marital Status 12. Was Decedent Ever in U.S.	20659 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14 Bac	e - Americ	an Indian,	
1215-0036	ital Hygiene. dother than "naturel", or itema 23a or 28e-1 show event, it a Medical Exert in mr. mail be rediffied at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Blac	k, White,		
<u> </u>	[E.]	by	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify	· Whi	te	
۽ ج	natu	Completed	(Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of work	tina	16b. Kind of Bu	siness/In	dustry	
Maryland 21215-0036	al Hygiene.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)					
2	ntal Hygie od other t event, ti	ပိ	12 17. Father's Name (First, Middle, Last)	Farmer 18. Mother's Nam		Agricultu			
and	ed o) Be				Wallett Sullalli	10)		
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S	1 = 1 = 1			New Market Turner Road					50
ē, j	Department of Health Importent: If item 27 any injury or other tre		20a. Method of Disposition 20b. Place of Disposition	isposition (Name of crematory or other place)	Date	20c. Location -			19
SE SE	nt: If		LAbrilla 2 Command 3 Chemova nom State	l Ma	2005	Waldorf,	Marv	land	
Baltimore,	Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility			riary.	Land	
n s	22 = 2		Michael Sardiner	Mattingley-Gardiner Fune P.O. Box 270, Leonardtow	eral Home, Mn, Maryla	P.A. nd 20650			
E	bhysician and water transit the burial-transit	dicai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of)	umonia	_		-	Interval Bett Orlest and I	ween Death
O. Box 6	e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Mor	e of delive	-	Year
ords, P	5 6	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		oacco use contr es 2 (a No		e cause of d ably 4 □U	
Hec F	has b	Completed	Demanlia		24a. Was a autops perform	ned? d	Vere autor rior to cor leath?	osy findings a npletion of ca	available ause of
		Φ	25. Was case referred to medical	26. Place of Death				2 140	
> 1	this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpi	atient 3 DOA Other: 4 Nursing Ho	me 5 Reside	ence 6 Othe	er (Specify	r)	- 5
VISION OT VITA	aath. or: After th he funeral	ation;	27. Manner of Death 1		28d. Describe ho	ow injury occurre	ed		
/ DIVISION	rs after death rel Director: led in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (St City or Town	reet and Numbe n, State)	or Rura	l Route Numi	ber,
) de Ho	within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, control of the basis of examination and/control one) 1 Medical Examiner: On the basis of examination and/control one)	or investigation, in my opinion, death occurr	red at the time, d	ate and place, a	nd due to	the cause(s))
1 5	To To	2	29b. Signature and title of certifier	29c. License number	7 2	9d. Date signed	(Month, L	Day, Year)	-
			30. Name and address of person who completed cause of death (Item 23a) (Ty	ne Print)		5-0	× 2	~	
				Notch Road, Hollywoo	od, Mary	land 20	636		
	Sta Registr		31. Date filed (Month Day, Year) 2 2005	house					

			1- State of Maryland /	Department of Health and	Mental Hyg	ienen n	15	1501.0
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Re	eg. No.		1 1 2 4 2
	Physic	cian			2. Date of Deat Month	h Day	Year	3. Time of Death
	/Med				April	00'	2005	4:40 p.m
1	Exam	iner		4b. Cify, Town, or Location of Death	1	4c. Count	y of Death	
	Funera		43710 Abe11 Farm Way 5. Social Security Number 6. Sex 7. Age (In yrs. last by	Leonardtown irthday) If Under 1 Year If Under 24 Hrs.		St.	Mary	
	Director		_579-24-8955 1□M XXF 80	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		9. Birthpi Coun	lace (State or Foreign
	p		Usual Residence of Decedent		Nov. 13,	1924	Mary	1and
	anylar show	_		wn or Location			10	Od. Inside City Limits
	89-f	ct	Maryland St. Mary's	Leonardtown				1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of	What Count	trv?
	ath w			20650			ed Sta	
	s 1 and 2 should be filed within 72 hours after death with the Maryiand f Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23a or 28e-f show other traumatic avent, the Mardial Examinor in ust be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Rac	e - America	an Indian.
36	s aft	by F	If Yes, Give	1 Yes 2 No Specify:	Hican, etc.)	Blad	ck, White, e	etc.
21215-0036	hour tural	pe	Year or Dates:			Specify	Whi	te
5	in 72 " na Long	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ina 1	6b. Kind of Bu	usiness/Indi	ustry
7	with than	E C	Elementary/Secondary (0-12) College (1-4or 5+)	irre. DO NOT use retired)				
	filed Hygie other			Home Maker		Own 1		
Maryland	Mental Mental arked o	To Be	_		e (First, Middle, Ma	aiden Sumam	10)	
JE /	2 should and Men Is marke sumatic	-		Bertha	Wheatley	T=1.11		
	and 2 ealth a n 27 Is			D. Mailing Address (Street and Number or Rur				Code)
ē,	ss 1 and of Health Itam 27		20a. Method of Disposition 20b. Place o	279 Bennett Drive Ri	dge, Mary	land 2	20680	
<u>ا</u>	Pages nent of I nnt: If Its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ry, crematory or other place)		c. Location -	City or Tow	m, State
Baltimore,	permit. Pages Department of Important: If II any injury or o		21. Signature of Juneral Service Zicensee	eorge Cemetery 5-2-	2005 \	/alley	Lee,	Maryland
ñ	Dep Imp any		2 duller	22. Name and Address of Facility Bri	nsfield H	[unera]	Home	P.A.
	× .			I F.U. DOX //9 Leona	rdfown N	10 m 17 1 0 m	nd 206	50-0279
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	and a cardiac of dying, such as cardiac of	or respiratory arrest	t.	[]	Approximate nterval Between
	Physician /Medical		disease or condition resulting in death)	nomplotes			1	Onset and Death
	Examiner		Due to (or as a consequence	of):			- //	wrang
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	ry Carcinom	a			145
	uted J ansit	m in	Cause (Disease or Injury	5,,			7	1
5	exec in an	Examin	that initiated events resulting in death) Last C	of):				
00/00	icate be executed physician and the burial-transit							
0	rificate be executed g physician and as the burial-transit	edical	u					
5	eath cer attendin for use	M/ul	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					
	The law requires that the death cerate has been signed by the attendir oage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 ♣No 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Mont	of delivery	y Year
	by the	hys	9 ☐ Unknown 9 ☐ Unknown					,
'n	as the	by P	Part II. Dther significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contrib	oute to the o	Cause of death?
2	w require							y 4 Unknown
2	aw re	Completed	Dialekal		24a. Was an			
	The lay cate has page 2	Eo	July eva		autopsy performed	_ Dii	ere autopsy or to compl ath?	findings available etion of cause of
		O	25. Was case referred to medical		1 Yes 2		Yes 2	No
-	is dir	0 8	examiner? 1 Yes 2 No	26. Place of Death				
	g Ph ter th neral	_ :u	27. Manner of Death 28a. Date of Injury 28b. Ti	Satisfit 3 DOA 4 Nursing Hom	e 5 X Residence			
2	Attanding It death. actor: After by the funer	atio		me of 28c. Injury at 29c. Work? M 1 ☐ Yes 2 ☐ No	od. Describe now in	ijury occurred	1	
2		ertification	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, fam		3f. Location (Street	and North		
1	tal or s afte el Dira	Ceri	building, etc. (Specify)		City or Town, St	ate)	or Hural Ho	oute Number,
	To the Hospital or within 24 hours after To tha Funarel Discompletely filled in		29a. Certifier (Check only Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, as	od due to the server	(-) - · · ·		
	he H in 24 ha Fi plete	edical	(Check only one) Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurred	at the time, date a	i(s) and mann and place, and	er as stated due to the	d. cause(s)
1	To the Hospital c		29b. Signature and title of certifier	29c. License number		Date signed (/		
			Jamest holowally) DOLLIG	, //	1-01	\ _ ^	,
			30. Name and address of person who completed cause of death (Item 233)	voe. Print)	7	750	74	5
			J. Patrick Jarhoe M D. 24035 Thr	see Notah Pood Hall-	reed to	20000		
	Stat	e '	31. Date filed (Moving Car Year) 2 2005 32. Segistrar's Signature	Indeen Road, north	wood, MD	20636		
	Registra	r	VIII/1 0 % 2003	A STATE OF THE STA				

			For State Registrar		State	of Ma	ryland			of He		Mental I	Hygier Reg. 1	time for the last	5	15950	
1			1. Decedent's Name	(First, Middle, Las	st)	-						2. Date o	Death			3. Time of Death	_
	Physicia /Medic		BENSON	DAVID AI	AMS							Month APR		6, 200	ear 5	10:30A ^M	
	Examin		4a. Facility Name (If I	not institution, give		umber)					ocation of Dea	ith	4	4c. County of	Death		
			5106 Vik	ing Road					Beth					Montgo	mery	7	
	Funeral		5. Social Security Nu		ex OXM 2□F		(In yrs. lasi	-	If Under Months		f Under 24 Hr Hours Mir	S. 8. Date of	Birth Day, Yea	ar) 9	. Birthpli	ace (State or Foreign	}
L	Director		174-32-94	00	77 N 2 1	L		Yrs.				03/06	/1942	2	Count	PΆ	
	and and	}	Usual Residence of D	10b. County			10c. City, 1	Town or Lo	cation				_		10	d. Inside City Limits	—
	Manyl f sho	ō	MD I	Montgome	ry		Bethe	esda								1 X Yes 2 □ No	
	the 288	Director	10e. Street and Numl	ber		1			10f. Zip	Code			10g. (Citizen of Wh	at Count	rv?	_
	death with the Maryland ms 23e or 28e-f show Frival Le notified at		5106 Vikin	no Road					208					ited S		•	
	death ms 2	Funerai	11. Marital Status	ng noad	12. Was De	cedent Ev	ver in U.S.	13. V			anic Origin? (Specify Yes o		14. Race -			_
0	or Ite		1 Never Marrie	d 2X Married	Armed F 1 ☐ Yes	2X No			_			rto Rican, etc.)		White, e		
3	ral', c	by	3 Widowed 4	Divorced	If Yes, G Year or	ive Dates:		'	☐Yes 2	No S	Specify:			Specify: \	Whit	e	
215-0036	72 ho	Completed	(Specif	15. Decedent's Ed y only highest gra	lucation de completed	')	1	16a. Deced	lent's Usua	Occupation	on ing most of w	orkina	16b.	Kind of Busin	ness/Ind	ustry	
7	ithin	ldu	Elementary/Second			(1-4or 5+	,	lito I	ON NOT US	a ratirari)	0	onang					
7	ed w ygier ygier ygier th	Co			5+			Comma	nding		nt To ral			•	nt c	of Defense	-
yland	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or Items 23a or 28a-f show event. If a Marical Examiner must be notified at	Be	17. Father's Name (F	First, Middle, Last)						18	B. Mother's Na	ame (First, Mid	ddle, Maid	en Sumame)			
<u>X</u>	2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "natural", or flee eumetic event. It a Modical Examination	T ₀	Arthur L									Krame					
Mar	2 sh n and is m		19a. Informant's Nan	ne/Relationship (Гурө, Print)		- 6	19b. Mailin	g Address	(Street and	d Number or F	Rural Route Nu	imber, City	y or Town, Sta	ate, Zip (Code)	28
	l and lealth im 27 her t		Natalie A		<u>ife</u>						d Beth	esda, l	_				_
0	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic evonce.			Cremation 3		State	cem	e of Dispos etery, cren	natory or ot	her place)				Location - Cit	ty or I ov	m, State	1
	tmen tent: tent:		`4 □Donation 5			9	Roose	evelt				28/200.	5 Tr	evose,	PA		
saltimore,	ermit Depar npor ny in		21. Signature F	dra Service Lice			EF	(DH 1	. Name and	inald	of Facility	ral Ho	me. T	nc			
_	70 = 9 d		14 4	lyn	$\sim \gamma$	7-7								r Spri		MD 20904	
				failure. List only	one cause on	each line	he death.	Do not ente	er the mode	of dying, s	such as cardia	ac or respirato	ry arrest,			Approximate Interval Between Onset and Death	
	Physician	1	Immediate Cause (F disease or condition resulting in death)		a Met	tasta	atic (Colon	Canc	er						Month	
	/Medical Examiner	- 1	resulting in death)		Due to	(or as a	consequer	nce of):									
		e	Sequentially list cond	ditions,	b. Dun to	105.20.2	consequer	of\.									-
	led nsit	nine	if any, leading to imm cause. Enter Underli Cause (Disease or in	ying	200 (0	(UI as a	corisequei	ice or).									
	xecul and sl-trar	Examin	that initiated events resulting in death) La		c. Due to	o (or as a	consequer	nce of):									-
8/60,	icate be executed physician and s the burial-transit					`	·	,									
ğ		edical			. d										+		-
X	death certific e attending p id for use as	/We	IF FEMALE: 23b. Was decedent	orognant	23c. If yes, or	utcome o	f pregnancy	y						23d. Date o	of deliver		
n	atter atter	Physician/M	in the past 12 m	nonths?			Fetal de		Ectopic pre					Month		y Day Year	1
j.	y the	ıysi	9 ☐ Unknown	No	9□ Unki				(0)								
J.	requires that the de een signed by the a nould be detached f		Part II. Other signific	ant conditions o	ontributing to	death but	not resultin	ng in the ur	derlying ca	ıuse given i	in Part I.	23e. D	oid tobacco	o use contribu	ate to the	cause of death?	
cords,	uires sigr	d by										1	☐Yes	2 X No 3(☐ Proba	bly 4 □Unknown	
<u> </u>	- Q 70	ompleted										24a V	vas an	24h Wa	ra auton	sy findings available	
Ě	The law ate has b page 2 sl	E .										a	utopsy erformed?	prio	r to com	pletion of cause of	
ā	vicien: Th certificate rector, pag	e Co	25. Was case referre	d to modical								1 □ Ye	es 2X71		Yes 2	P No	_
>		o Be	examiner?		Hospital:] Inpatien		VOutpatien	20.00			eath <i>(Check or</i> Home 5 🕅 F		a Cloub			i
Ö	Phys or this oral di	\vdash	27. Manner of Death		28a, Date	of Injury	28	Bb. Time of		Bc. Injury at Work?	4 Nursing			jury occurred	(Specify)		-
0	Attending Ph ar death ector: After th by the funeral	tlor	1 X Natural 2 ☐ Accident	5 Pending investigation	(Mo	nth, Day	Year)	Injury	м		s 2 No			, ,			1
VISION	Atteno death octor: y the	fica	3 🔲 Suicide	6 Could not be		e of Injur	y - At home (Specify)	e, farm, stre	et, factory,	office		28f. Locatio	on (Street	and Number	or Rural	Route Number,	-
\leq	ater Dire	Certification:	4 Homicide	dotominod	build	ding, etc.	(Specity)						Town, Sta				1
	spite		29a. Certifier	∑ Certifying Ph	ysician: To th	e best of	my knowle	dge, death	occurred a	at the time,	date and place	e, and due to	the cause	(s) and manne	er as sta	ted.	-
	To the Hospitel or Attenwithin 24 hours aller deal Within 24 hours aller deal To the Funerel Cirector: completely filled in by the	edical	(Check only 2 one)	Medical Exam	niner: On the	basis of e nner state	examination	and/or inv	estigation,	in my opini	ion, death occ	curred at the tir	ne, date a	nd place, and	due to	the cause(s)	
	To the within To the Comp	Me	29b. Signature and ti	itle of dertifier	۸				29c.	License n	umber		29d. D	Date signed (A	Month, D	ay, Year)	-
	20		> 70 M	~/0\	5	No.			n n	29675	5		04/	26/200)5		
	_		30. Name and address	ss of person who	completed cau	se of dea	ath (Item 23	3a) (Type, I	_		-	-			-		1
_			Ralph Bo	ccia, MI	6420	Rock	1edge			_ 41	LOO Bet	hesda	MD 20	0814			
	Sta		31. Date filed (Month	Day, Year)	05	Registrar	's Signatur	e Ana	MED.								
	Registr	ar	AF	40100	UJ FIA	To Allend	, KJ°	See Free			_						

APR 2 7 2005

Physician /Medical Examiner

Funeral Director

1 - For State Registrar			State of Ivia	arylano		tificate			vientai r	nygier Reg. N	2 U L)5	15951
Decedent's Name	e (First, Middle,	, Last)							2. Date of	Death			3. Time of Death
Faith Cl	narity A	Anti	guas						April	. 14	, 200	05 ^{Year}	9:43 Ам
4a. Fecility Name (I		-						ocation of Death	1		4c. County		
Washingto					- 4 1 2 4 1	Takom		ark If Under 24 Hrs.	Table		ontgo		
5. Social Security N None Usuel Residence of		6. Sex 1 ☐ N	7. Age	e (in yrs. ia	st birthday) Yrs.		Days	Hours Min. 3 5	8. Date of (Month)	Day, Yea 1/200	5	Cou	place (State or Foreign ntry) rland
10a. State	10b. County			10c. City,	Town or Lo	cation							10d. Inside City Limits
MD	Montgor	nery		Silv	er Sp	ring							1 X Yes 2 ☐ No
10e. Street and Nur 13901 Cas		ıleva	ard			10f. Zip C					Citizen of V		ntry?
11. Marital Status 1 X Never Marri 3			. Was Decedent I Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:					panic Origin? (S Mexican, Puert Specify:Cuba		No-	Blac	ce - Americk, White,	
(Spec	15. Decedent' cify only highest	s Educa t grade d	tion completed)		(Give	dent's Usual (kind of work	done du	ion ring most of wor	king	16b.	Kind of B	usiness/In	ndustry
Elementary/Seco	ndary (0-12)		College (1-4or 5	+)		ne noruse	retirea)			No	ne		
17. Father's Name	(First, Middle, L	.ast)		I			1	8. Mother's Nan	ne (First, Mid	ldle, Maid	en Suman	ne)	
Richar A	ntiguas							Tamika C	Charity	y Pet	ers		
19a. Informant's Na								d Number or Ru		-			
Tamika C		s, M	other					ulevard					
20a. Method of Dis 1 Burial 2 3 Donation	Cremation		noval from State	cer	metery, cren	sition (Name matory or other ln Cres	er place)	ry 04/29	Date 9/2005				own, State
21. Signature of P	meral Service L	icensee	4		- 1			of Facility Si	-			aryla	and 20852
23a. Part1. Enter t shock, or hea	he disease, or o	complica only one	tions that caused cause on each lir	the death.									Approximate Interval Between
Immediate Cause disease or condition resulting in death)	(Final on	a.	Sever	e Pu	linena	ing He	JPO.	plasia	_ Dila	Tero	P		Onset and Death
Toolary III Godiny	ì		Due to (or as	a conseque	ence of):	` _ ` _	00	plasia	م شد	1			
Sequentially list co	nditions, nmediate	b	Due to (or as	a conseque	ence of):	enilz	x ce	CEPHICLE	matri	c ne	mia		
cause. Enter Under Cause (Disease or that initiated events	injury	· c											
resulting in death)	Last		Due to (or as	a conseque	ence of):								
	1	d			-					-			
IF FEMALE:		230	. If yes, outcome	of preopan	ON /								
23b. Was deceden in the past 12	months?	200	1☐Live birth 4☐Pregnant at	2 Fetal c	death 3□	Ectopic preg Other (spec						te of delive anth	ery Day Year
1 ☐ Yes 2 9 ☐ Unknown			9□ Unknown										
Part II. Other signif			buting to death bi	6.	ting in the ur	nderlying cau	ise given	in Part I.			o use cont		he cause of death?
Jest	e15.ex	Lid	odu.						24a. W	/as an	24b. \	Were auto	opsy findings available
Pro	matrix	eli.	dusin	nenn	hic	il ato	P 1 A 2	- ·		utopsy erformed? is 2 1 1		prior to co death? 1 X Yes	mpletion of cause of 2 No
25. Was case refer	red to medical	7		7	71.0	Jac har c		26. Place of Dea			40	74.00	20110
1 ☐ Yes 2		Hos	-			t 3□ DOA		4 Nursing n	ome 5 A	esidence	6 □Oth	er (Specii	fy)
27. Manner of Deat	5 Pending		28a. Date of Injui (Month, Da)	Year) 2	28b. Time of Injury		Work?		28d. Descri	be how in	jury occuri	red	
2 Accident 3 Suicide	investig 6 ☐ Could n	ot be	28e. Place of Inju	iny - At hor	ne farm str	M eat factory (s 2 No	28f i ocatio	n (Street	and Numb	ar or Rur	al Route Number.
4 Homicide	determi	nea	building, etc	. (Specify)	10, 141111, 3()	oot, ractory, t	011100			Town, Sta		or mure	ar mobile warnber,
29a. Certifier (Check only one)	1 Certifying 2 Medical E	g Physic Examine	r: On the best of and manner sta	examination	ledge, death on and/or inv	n occurred at vestigation, in	the time	, date and place nion, death occu	, and due to rred at the tir	the cause ne, date a	(s) and ma	anner as s	stated. o the cause(s)
29b. Signature and	title of certifier					29c. 1	License r	number		29d. E	ate signe	d (Month,	Day, Year)
D Q	vo thus	. A	Hara	cm	5		23	109		1	413	5/05	
30. Name and addr			pleted cause of d	eath (Item 2	23a) (Type,								
Dorothy H), 7					ma P	ark, Ma	ryland	209	12		
31. Date filed (Mon	R 2 7	2005	2. Registra	ai s signatu	ire Again	120							

DHMH 17 Rev 1/2001

State

Registrar

			1 - For State Registrar	State of I	Marylan		artment of H tificate of L		d Mental Hy	giene Reg. No	000	159	52
			1. Decedent's Name (First, Middle, Last)		- <u></u>				2. Date of De	ath Day	y Year	3. Time of	Death
	Physici /Medic		Betty A. Barnes						April	24	2005	9:00	P M
	Examin		4a. Facility Name (If not institution, give	street and number	er)		4b. City, Town, or	Location of De			County of Death		
1			Suburban Hospita	1			Silver S	Spring		F	rince Ge	eorge	
	Funeral		5. Social Security Number 6. Sex	7.	Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 F		th		place (State o	or Foreign
	Director		577-38-7091	M 2DF	73	Yrs.	Months Days	Hours N	lin. (Month, Da Sept. 2	11. 1	931 Wash	n in gtor	n D.C.
	D		Usual Residence of Decedent										
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside Ci	-
	Ma -i-a	cto	Maryland Montgomer	у	Bet	hesda						X Yes	2 🗆 No
	or 28	Olre	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	ntry?	
	23a	alt	6504 Wilmett Rd				20817			U.	S.A.		
	filed within 72 hours after death with the Manyland Hygiene. ther than "natural", or tems 23a or 28a-f ehow ant, the Medical Exertiment to modified at	by Funeral Director	11. Marital Status	12. Was Decede Amed Force	ent Ever in U. es?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.))-	14. Race - Ameri Black, White,		
9	or it	Y FL	1 Never Married 2 Married	1 Tes 2]	No No		1 ☐ Yes 2X No	Specify:			Specific		
21215-0036	irai',	d b	3 Widowed 4 □ Divorced	Year or Date	s:						wni		
5	72 r	Completed	15. Decedent's Edu (Specify only highest grade			(Give	dent's Usual Occupa kind of work done of	turing most of	working	16b. K	ind of Business/In	dustry	
2	han ne	шb	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use retired	,					
2	led w lygien her ti	Ö	12			Mana	ger	10 Mathada I	Nome (Circle & Goddle		nsportat	ion	
Maryland	tat H d otl	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle		Sumame)		
<u>Ş</u>	ould Men Parke	ို	Abner Lakenan						uerite Ro				
<u>a</u>	2 sh and ie m		19a. Informant's Name/Relationship (Ty						Rural Route Numb				
	and ealth n 27			on	1221	_		Pl Bet	hesda, Ma				
ore	of H fite		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ R	emoval from Sta		lace of Dispo emetery, crei	sition (Name of natory or other plac	θ)	Date	20c. Lo	ocation - City or To	own, State	
<u>E</u>	Pag ment ant: ury c		' 4 ☐ Donation 5 ☐ Other (Specify)		1	Comfor	t Cremato	ry Ap	ril 27,05	A1	exander.	Va.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any fourty or other traumatic event, the Medical Exacting Institute at an ance.		21. Signature of Funeral Service Licens	PR		22	. Name and Addres	s of Facility	Joseph Ga	wler	's Sons,	Inc.	
	90 E # 9		Williamy K	, Du	gy	5	130 Wisco	nsin A	ve N.W. W	ashi	ngton, I	.C. 20	016_
			23a. Part1. Enter the disease or complishock, or heart failure. List only or	cations that cause on each	sed the death h line.	n. Do not ent	er the mode of dying	g, such as card	diac or respiratory a	rrest,		Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	M	etas	Lat i	c Lua	. (ncer			Onset and I	
	/Medical		resulting in death)		as a consequ)	0.00		-		• 7
	Examiner		Sequentially list conditions.	1									
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or	do di consequ	usnos of).							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events										
0	an al	E	resulting in death) Last	Due to (or	as a consequ	uence of);							
8760,	ysici	dlcal		j									
9	ng pt as ti	Jed	IF FEMALE:										
Вох	death certiff e attending id for use as	Jue /	23b. Was decedent pregnant 2	3c. If yes, outcome 1 Live birth	me of pregna		Ectopic pregnancy				23d. Date of deliv	•	
	deal	lc ls	in the past 12 months? 1 2 Yes 2 No		it at time of de		Other (specify)				Month	Day 1	Year
P.0	by th	hys	9 Unknown	3 CI KI OWI									
	requires that the death certiff een signed by the attending hould be detached for use as	by Physician/Me	Part II. Other significant conditions con	ntributing to deat	th but not rest	ulting in the u	nderlying cause give	on in Part I.			use contribute to t		
Records,	quire an sig uld b								1 🗆	Yes 2	No 3 Pro	bably 4 🔲	Jnknown
၀		let							24a. Was		24b. Were auto	opsy findings	available
Be	The law ate has b bage 2 sl	Completed								ormed?	death?	impletion of c 2□ No	ause or
Vital			25. Was case referred to medical					26 Place of I	1 ☐ Yes Death (Check only of	2 √No	1 195	2 140	
5	Physician: this certific ral director,	o Be	examiner?	lospital:	atient 2 🗆	EB/Outpation	t 3 DOA Othe	nn .	g Home 5 ☐ Resi		6 MOther (Speci	4.1	
o		. To	27. Manner of Death	28a. Date of I (Month,		28b. Time o			28d. Describe			197)	
o	ding Phy h. After thi funeral c	tor	1 ♣Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury		<br Yes 2 □ No					
S	Attending r death. sector: After by it e fune	E S	3 Suicide 6 Could not be	28e. Place of	Injury - At ho	me, farm, str	eet, factory, office		28f. Location (Street ar	nd Number or Run	a <i>i R</i> oute Num	iber,
Division	or A after Direction by	Certification:	4 Homicide	building	, etc. (Specify	1)	001, 120101, 1, 011100		City or To	wn, State	9)		
	urs urs eral filled		29a. Certifier 1 Certifying Physical Ph	sician: To the he	est of my kno	wledge, deat	occurred at the tim	ne, date and ni	ace, and due to the	causals	and manner as	stated.	
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Exami	ner: On the basi and manner	is of examinat	tion and/or in	vestigation, in my or	oinion, death o	ccurred at the time,	date and	d place, and due t	o the cause(s	;)
	To the Hospital or Attendi within 24 hours after death. To the Furieral Director; A completely filled in by the fu	Me	29b. Signature and title of certifier				29c. License	number		29d. Da	te signed (Month,	Day, Year)	
	->-0		1		m 1		DK	6652		Adr	124	1 00 5	
0	Tul		30. Name and address of person who co	impleted cause of	of death (Item	23a) (Type	Print)			-		J	
	(7)			enroth		910	of Med	ical C	enter pr	in	ROCKL	ill A	UD
	Sta	ate	31. Date filed (Month, Day, Year)	■ Reg	istrar's Signa					***/			
	Regist		APR 2 8 2005	E .	- 4	· Ann	AL A						

DHMH 17 Rev 1/2001

Boulms, 180thy Anne 4124105 2120

		_	1 - For State Registrar	State of M	arylan		artmen rtificate			and M		giene	005	la fire	059
	Physici /Medic		Decedent's Name (First, Middle, Last) Francis	Clemens	Brah	ler					2. Date of De. Month May 3	Day	Year	3. Time 5:26	of Death M
	Examir		4a. Facility Name (If not institution, give :	street and number)					Location of				ounty of Death	_	
	Funeral		37681 Asher Road 5. Social Security Number 6. Sep	7. Ag	ge (In yrs.	last birthday)	If Under	1 Year	icsvi If Under	24 Hrs.	8. Date of Birt	h	int Mar 9. Birth		or Foreign
	Director			XM 2□F		98 Yrs.	Months	Days	Hours	Min.	(Month, Da July 16,				Columbi
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event, Ira Medical Examinating the ruillised at ODGs.	To Be Completed by Funeral Director	Maryland Saint Mar 10e. Street and Number 37681 Asher Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) George Thaddeus Brahle 19a. Informant's Name/Relationship (Ty	12. Was Decedent Armed Forces' 1	Mec	16a. Dece (Give life. Airl	11e 10f. Zip 20 Was Deced f Yes, spec 1 Yes 2 Indent's Usua kind of wor DO NOT us ine Me	ent of Hi ify Cuba 2 No 1 Occupa k done c e retired chani	Specify: ation furing mosi 18. Mothe Cathe	or's Name	e (First, Middle, Margaret	USA 14. Sp 16b. Kind Aircra Maiden Su Giebel	l own, State, Zi	ican Indian, etc. ce industry	es 2⊠No
Baltimore, I	permit. Pages 1 and Department of Healt Important: If item 2' eny injury or other: QDC9.		Joan Turner / Daughte: 20a. Method of Disposition 1 \(\mathbb{B}\) Burial \(2 \subseteq Cremation \(3 \subseteq R \) 4 \(\subseteq Donation \(5 \subseteq Other (Specify) \) 21. Signature of Fune (Service License)	emoval from State	'	Place of Dispo cometery, crea Mary's	cition (Name and Martin	e of her place ry d Addres ng Le	e) Is of Facility—Gai	May 6	ville, Ma Date , 2005 er Fune: ardtown	20c. Locat Washing	tion - City or T gton, DC		
8760,	Physician /Medical Examiner	dical Examiner	23a. Part. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):					uzi			Approxim. Interval B Onset and	etween
P.O. Box 68	t the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic pro					23d	I. Date of deliv Month	ery Day	Year
Ś	w requires that been signed should be del	by	Part II. Other significant conditions con	tributing to death t	out not res	ulting in the u	nderlying ca	iuse give	an in Part I.	·	101	es 2	contribute to	bably 4	Unknown
Record		Completed									24a. Was autop perfo 1 \(\text{Yes}	sy	24b. Were auto prior to co death? 1 ☐ Yes	opsy finding ompletion of	
Vital	yslcien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:				Othe	200		(Check only o				
DIVISION OF		ertiflcation; To	1 Yes 2 No. 27. Manner of Death 1 Hatdral 5 Pending 2 Accident investigation	1 ∐ Inpati 28a. Date of Inju (Month, Da	ıry	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	at		me 5 Fesio 28 Descrie I		Other (Speci ccurred	fy)	
DIVIS	in Dir	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factory	office			28f. Location (S City or Tow	Street and N n, State)	lumber or Rur	al Route Nu	m <i>ber</i> ,
40	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier Certifying Physical Check only one)	sician: To the best ter: On the basis of and manner st	of examina	wledge, death ition and/or in	occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the ded at the time,	cause(s) an date and pla	d manner as s ace, and due t	stated. o the cause	(s)
	To the within To the comp	Me	29b. Signature and title of Sertifie						991	7		29d. Date s	igned (Month,	Day, Year)	
	Sta Registi		30. Name and address of person who ce 31. Date filed (Month, Day, Year) MAY 0 4 2	32. P gist	death (Item rar's Signa	51,	Print) MARI Conti	15/	UED	AS.	soc,	CALI	FORNIA	, MD.	2069

ADH DAMON BROWN 05-2919

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

.9		1 - For Stete Registrar	State of M	Maryland / De	-	of Health of Death			ene () ()	5	159	54
Physici	an	Decedent's Name (First, Middle, Damon Bro						2. Date of Death	27°, 200		3. Time of 0600	Death a M
Medic Examin		4a. Facility Neme (If not institution, I 95 SOUTHBOUND	give street and numbe	JE MARKER	4b. City, T ABERI	own, or Location OEEN		ZH KIL	4c. County of HARFORI	Death		
Funeral Director		217-58-8302	5. Sex 7. / 1 ☑ M 2 ☐ F	Age (In yrs. last birtho	Months	Year If Unde Days Hours	Min.	8. Date of Birth (Month, Day, Nov. 28	, 1952	Country	ginia	
Maryland b-f show lited at	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Ha	rford	10c. City, Town o		e de Gra	ace			10d	I. Inside Cit	
with the ta or 284	Directo	10e. Street and Number 108 Stansbi	ırv Court		10f. Zip (ode 21078		10	g. Citizen of Wr Unite			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f ehow amy injury or other traumatic event. The Modical Examinational Demotlined at once.	by Funeral	11. Marital Status 1 □ Never Married 2X Marrie	12. Was Decede Armed Force 1 Yes 2 [s?]No	13. Was Decede	nt of Hispanic O y Cuban, Mexica	an, Puerto P	cify Yes or No- lican, etc.)	14. Race Black,	American White, etc	Indian,	
thin 72 hours e. en "neturel" Modical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	(C	ecedent's Usual Give kind of work fe. DO NOT use	done during mo	ost of workin	g 1	6b. Kind of Busi			
lbe filed wit ntal Hygiene ed other the event, the	Be	12 17. Father's Name (First, Middle, La		Dep	t Public	18. Moth		t Worker (First, Middle, M			overn	ment
2 should and Mer Is mark sumatic	2	James Gamble 19a. Informant's Name/Relationshi	p (Type, Print)			Street and Numb	ber or Rural	Route Number,				
ges 1 and it of Health If item 27 or other tr		Vivian Brown / V 20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3	Vife 3 □Removal from Sta	20b. Place of D	isposition (Name crematory or oth	er place)	Da		0c. Location - C	ity or Town	n, State	
permit. Pa Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Special Service Li		St. Jan	nes Unit 22. Name and Lisa	Address of Faci Scott F	5/4, Tunera	1 Home, Havre	P.A.	Ness	Constanting	
Physician bhysician and physician and the bnuist transit state is the bnuist transit	dical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of limited and the shock of heart failure. List of limited and the shock of heart failure. List of limited and the shock of the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and the shock of limited and l	a. Multiple to (or a Due to (or	as a consequence of):	uries	of dying, such a	is cardiac or	respiratory arres	st,	In	pproximate nterval Betv Onset and C	ween .
that the death certific ed by the attending p detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 ⊟Ectopic pre- 5 ☐ Other (spe-				23d. Date Month	-	ay Ŷ	′êa7∽
w requires that to been signed by should be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in th	ne underlying ca	use given in Part	t I.	23e. Did toba	acco use contrib	ute to the		eath? Inknown
siclan: The law re certificate has bee lirector, page 2 sho	Completed							24a. Was an autopsy perform	ed? de:	ere autopsy or to comp ath? Yes 2[y findings a letion of ca	ivailable iuse of
ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 No	Hospital: 1 ☐ Inpa	itient 2 ☐ ER/Outpa	atient 3 DOA	Cabon		(Check only one		(Specify)	SCEN	E
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion 4-37.	njury 28b. Tim Day Year) 28b. Tim Injury - At home, farm etc. (Specify)	¥5 M	c. Injury at Work? 1 □ Yes 2 office	(No F	Bd. Describe how ASSCAC Bf. Location (Street City or Town,	est and Number	iden	So. Y	ber, Mile
e Hospit 24 hour e Funera etely filla	edical	29a. Certifier 1 Certifying 2 Medical Ex	Physicien: To the be caminer: On the basis	of examination and/o	death occurred a or investigation, i	t the time, date a n my opinion, de	and place, a eath occurre	nd due to the cod at the time, dat	se(s) and mann te and place, an	ner as state d due to th	ed. ne cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier	ronii-	Bller +	29c.	License number OCME	7		d. Date signed (Month, Da		
30 1 k	te	30. Name and address of person w PAHRICIA AC 31. Date filod (Month, Day, Year)	nica-Pa	f death (Item 23a) (Ty	PENN ST	REET, B	BALTIM	ORE, MAR	RYLAND 2	1201		
Registr		Arn 28 200	DER	Dr. Page	and the same							

Months

10f. Zip Code

20854

1 ☐ Yes 2 ☐ No Specify:

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Bruccoleri

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 致入No If Yes, Give Year or Dates:

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

Potomac

Randolph Hills Nursing Home

Certificate of Death

2. Date of Death

Apri1

March 25, 1919

Month

4b. City, Town, or Locetion of Death

Wheaton

If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

3. Time of Death

10:25 AM

Year

Montgomery

New York

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 21 No

27, 2005

4c. County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

U.S.A.

Specify:

Physician

1. Decedent's Name (First, Middle, Last)

Nancy

5. Social Security Number

10a. State

Maryland

11. Marital Status

10e. Street and Number

054-01-7029 Usual Residence of Decedent

Edith

10b. County

9440 Newbridge Road

1 ☐ Never Married 2 ☐ Married

3√Widowed 4 Divorced

Montgomery

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 🔀 F

5 W	اع	3 ₩ Widowed 4 Divorced	Year or Dates:					Specin	White	
the Medical Ex	Completed	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	16a.	Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation one during most of	vorking	16b. Kind of B	usiness/Industry	
e We	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)							
#	ပ္ပ	. 12 17. Father's Name (First, Middle, Last)		0	ffice Man	-	Nam <i>e (First, Middle</i>	Health		
	Be								10)	
	၉	Louis Morelli 19a. Informant's Name/Relationship (7)	ivna Print)	106	Mailing Address (Str		Capilong		State Zin Cond-1	
ł	1				199424				. ,	
	1	Ted Bruccoleri (20a. Method of Disposition		Place of	510 Longfo Disposition (Name of compart or other	ellow Str	eet, McL	ean, VA	22101 City or Town, Stat	te
		13☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemovar irom State			place)	1.100.100			
	1	21. Signature of Funeral Service Licens	OLICI	tenna	m Cemetery 22. Name and Ad	dress of Facility	4/29/05	Cheltenha	m, Marylan	d
		marian Ja	_		1102 W.	dress of Facility Broad St	rpny rai	ls Unurc	n Funera	1 Home
+	-			h Don				•		imato
l		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one ceuse on each line.	ii. D0 ii	or enter the mode of	dying, such as care	nac or respiratory a	irest,	Approx Interval Onset a	Between and Death
ı		Immediate Cause (Final	C							
l r	-	disease or condition resulting in death)	a END STAC			BSTRUCTIV	E PULMOI	NARY DIS	EASH 14	CAR
	ē		Due to (d	or as a c	onsequence of):				i I	
	Examiner	Sequentially list conditions	b. Due to (c	resac	onsequence of):					-
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 (0	00 u o	oneoquenee on.					
	Ca	that initiated events	cDue to (o	rasaco	onsequence of):					
	2	resulting in death) Last	·							
should be detached for use as the burial-transit	2		d							
	SIC	Part II. Other significant conditions co	ntributing to death but not res	ulting in	the underlying cause	given in Part I.	23b. Did	tobacco usa coi	ntributa to tha cau	ısa of death?
;	בֻּ בַּ	Hypoetry Ciordis	n, doman	Ti-			10	Yes 2□ No	3 ☐ Probably	4 🗆 Unknowr
	٥	Joseph agricus.	m , corrunc	Mar			-		I	
	Completed							an autopsy rmed?	24b. Were autop available pr	ior to
	ğ						-		completion of death?	OI Cause
	ទ្ធ 🛚						10	Yes 2 No	1 ☐ Yes	2□ No
1	ופב	25. Was case referred to medical examiner?	I I and the L				eath (Check only o			
i	<u>•</u>	1 142 5 6 140	Hospital:		patient 3 DOA	Other: 4 Thursing				
	6	27. Manner of Deeth 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti In		njury et Vork?	28d. Describe i	how injury occurr	ed	
1	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Please of testing And	(-		☐ Yes 2☐ No	206	Ctroot as at the sect	ar ar Dure / David	Alumba -
	E	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tari V	n, street, factory, offic	Ce .	City or To	vn, State)	er or Rurei Route N	vumber,
		29a. Certifier 1 Pertifying Phy	sician: To the heat of my line	wlodas	death occurred at the	time date and -1-	on and due to the	ooueo/s) and ===	nnor as otated	
	edicar	(Check only one)	stcian: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, tion and	or investigation, in m	y opinion, death oc	curred at the time,	date and place, a	and due to the caus	se(s)
		29b. Signature and title of certifier	and married states.		29c. Lice	ense number		29d. Date signed	d (Month, Dey, Yee	or)
		Ania	rosolnoAC	211	MID D	00576			28,20	
	-	30. Name and address of person who ca	ompleted cause of death (from	239) /7		000,70		10000		
		Arun Anuradtta MD				Spring	MD 20902			
		31. Date filed (Month, Day, Year)	Registrar's Signa		d -	obr mg,	10 20002			
T	-	APR 2 8 2005	Ken k		made a					
State jistra	r	MIN & 0 2000	Stone &							

			State of Maryland / Department of Health an 1- Store Amend Item 23a, 25, 27, 28a-f per me 1.843 5-19-05 t Registrar	d Mental Hyg as	giene 0 0	5 15956
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	_	3. Time of Death
	/Med	cal	Ruth Havener Bray	April	27 200°	5 7:08 P M
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	eath eath	4c. County of [Death
		74	St. Mary's Hospital Leonardtown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		St. Ma	ıry's
П	Funeral Director		1 M 2 F Months Days Hours M	vin. (Month, Da)	v, rear)	Birthplace (State or Foreign Country)
		-	Usual Residence of Decedent	Sept. 1	, 1918	Maryland
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Man Ff st	to	Maryland St. Mary's Mechanicsville			1 ☐ Yes 2 ₹ No
	r 28e	rec	Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
	36 o	0	27/00 1/1 1			,
	ours after death with the Marylan ral', or Itams 23e or 28e-f show Examinat must be mulfilled at	Funeral Director		(Specify Yes or No-	United	States American Indian.
9	after or Ita	Œ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pr	uerto Rican, etc.)	Black, V	Vhite, etc.
8	ral',	by	3 ■ Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: W	hite
21215-0036	72 hours after death with the Maryland "netural", or Itams 23e or 28e-f show coloral Examiner in ust by rollited at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of		16b. Kind of Busine	ess/Industry
2	filed within Hygiene. thar than "	ם	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	working		
7	filed w Hygier Ithar th	So	12 Budget Analyst		Dept. of	Defense
nd	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's I	Nam <i>e (First, Middle,</i>	Maiden Surname)	
<u>×</u>	2 should be filed withir and Mental Hygiene Is markad other than sumatic evant, It a Ma	2	Claude M. Havener Bes	sie Mae W	hittingto	n
Maryland	2 sh and ls m	0.1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number	r, City or Town, Stat	e, Zip Code)
	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene Item 27 is marked other then "netu other traumatic event, the Medical		John W. Bray / Son 27480 Misty Way, Mec	hanicsvil	le. Marvl	and 20659
Baltimore,	e = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date	20c. Location - City	or Town, State
Ë			'4 Donation 5 Other (Specify) Brinsfield-Echols Cr. 5-	1-2005	Charlotte	Hall MD
ä	permit. Pag Department Important: any njury o		21. Signature uneral School Consultation (Property of Security 1987)	rinsfield-	-Echols Fi	inl.HmeP A
_	20 5 20	1	Edward N. Brinsfield, Jr. M00052 30195 Three Notch	Rd., Charl	otte Hal	1. MD 20622
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory arre	est,	Approximate Interval Between
P	Physician		Immediate Cause (Final disease or condition	d		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			mendeles
9	Examiner		Sequentially list conditions b. Joula My Scardy A	herely	20/	Sala
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	L		y wine
	and trans	Examine	that initiated events c. Coronand Holland	Useas	911	4/2
90,	ficate be executed physician and s the burial-transit		Due to (or as a consequence of)	1 /	EDICAL EXAMINER	
68760,	ate b	edlcal	d	WIND BY K	EDICAL	
	E 6	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	A POR APPRO		
Box	death certifi e attending j id for use as	lan/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	V	23d. Date of	delivery
o O	the deay the a	Physici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
<u>С</u>	± > ⊃	Phy	3 El Gilliowii			
ŝ	Se Dec	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
0	w requir been si should I	ted	la = A ot	1 □ Yø	s 2 No 3	Probably 4 Unknown
Vital Records,	e taw has b	Completed	3/P Fracture of hip	24a. Was ar autopsy	24b. Were	autopsy findings available
	Th ate pag	50		perform	ed? death	o completion of cause of ? es 2 No
ij	i ician: Th certificate rector, pag	Be	25. Was case referred to medical axaminer? 26. Place of D	eath (Check only one		20110
o	hysi his c	ပ္	1€ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Resider	nce 6 Other (Sp	pecify)
_	ng P After I	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how		
Division	ttendideath.	cat	2 Accident investigation 4-24-05 M 1 ☐ Yes 2 No	Subject	fell	
\geq	lor At after d Diract I in by	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street, City or Town.	eet and Number or I	Rural Route Number. Misty Way
	urs a urs a iral C		At home	Mechanic	sville, M	ID .
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,	edical	29a. Certifier (Check only one) (Check one) (Check o	ce, and due to the car	use(s) and manner	as stated.
	within 2 To tha complet	Med	COL COLUMN A LINE ALLEY COLUMN AND A LINE ALLEY COLUMN	cured at the time, da	te and place, and di	Je to the cause(s)
	Co T wit		29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mor	nth, Day, Year)
			Demen Journa (1) 064	14	7-30-E	5
			30. Name and address or person who completed callse if death (Item 2 a 10th, int)	5140		
			JAMES P. JABORE M.D. PHILIP J. BEAN MEDICAL CENTER	HOLLYWOOD,	MD. 20636	5
	Sta Registra	le ar	31. Date filed (Month day, Year) 32 Registrar's Signature			
40	11091311					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 25 2005 **Physician** Frances S. Bray 9:45 PMM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 274 Southdale Ct. Dunkirk Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 13, 1918 9. Birthplace (State or Foreign Country)
Georgia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 247-30-8570 1 M 200 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a State or 28a-f show odical Examiner must be notified at 1 XYes 2 No Directo Maryland Anne Arundel Dunkirk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 274 South Dale Court 20754 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic assets. Completed by Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes XNo Specify: If Yes, Give Year or Dates: 3 →Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Cashier Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James J. Smith Jordan Ammie Wood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Teresa Arnold (Granddaughter) 274 South Dale Court, Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ARemoval from State Forest Lawn Mem. Pk. 4/30/2005 Anderson, SC A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 9013 Annapolis Road, Lanham, MD 20706 alemore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Al Zheimer's end -Sta disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of). P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 200 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2€ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045235 0 30. Name and address of person who comple a cause of death (Item 23a) (Type, Print) Dunkak, MD 20754 BIVD# 203 Town Center 31. Date filed (Month, Day, Year) State APR 2 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2005 April 28 23:11PM Harold Zimmerman Brewer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington County Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 81 Director April 11,1924 Maryland 216-14-6846 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State 28e-f ehow the Medical Examiner must be notified at Y☐Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 or Items 23a 21740 United States 916 W. Irvin Ave death 12. Was Decedent Ever in U.S. Armed Forces?

1X2 Yes 2 No 3-8-43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 9-30-45 "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hyglene. 7 le marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State Government 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Frederick Brewer Leah Zimmerman ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I 916 W. Irvin Ave. Hagerstown Maryland 21740

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - City or Town, State Thelma E. Brewer 20a. Method of Disposition Pages 1 Department of Importent: If it any Injury or conce. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Apr 30 05 Smithsburg Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Fone al Service Licensee 1331 Eastern Blvd. N. Hagerstown Mryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Pulmonary Fdenia Acute
Due to (or as a consequence of): Hours /Medical Examiner Arteriosclerotic Heart Disease Sequentially list conditions, I any k-a and to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of) Examiner certificate be executed the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus, Type II autopsy performed 2 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 V ER/Outpatient 3 DOA 2 1 Inpatient this 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation after death. Director: Af 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the ro the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Barnellak DOOO1040 04-29-2005

GH-11+1

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Antietam St. Hagerstown Maryland 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0"2 2005

Barry Cohen, 322 E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 1236AM Donna Lee Baker 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Pf Under 24 Hrs. 8. Date of Birth (Month Day Year) 03/23/1944 Examiner Washington Washington County Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 215-44-9966 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 23a or 28e-f ehow 1 Yes 2 No Completed by Funeral Director Hagerstown MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 US 55 E. Washington Street, Apt. 113 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Mary Barr Donald Daniel Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9800 Woodside Court, Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type, Print) Ray E. Shoemaker, Jr. / Son or other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit, Page Department of Important: If any injury or 5/2/2005 Smithsburg, MD * 4 □ Donation 5 □ Other (Specify) Smithsburg Cremator. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiration Pnysician Asystole /Medical Due to for as a consequence of): Examiner acidosis Severe Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Acute Ruabdom renal feulinel Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use : IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Day Month Year ŏ 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 27. Mannér of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-661 Madrais 062562 05/01/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAVI Ant tam 31. Date filed (Month) Da 32. Degistrar's Signature State Registrar

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mari mari	1	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Str	eet and Number or R	ural Route Numb	ber, City or Town, State,	Zip Code)
Mary nd 2 shou lith and M 27 is mar		ALAN BENSIMON, SON		3809	WENDY L	ANE, SILVI	ER SPRIN	IG MD 2090	06
Ore, Maryial es 1 and 2 should b of Health and Ment if item 27 is marked		20a. Method of Disposition	20b, 1	Place of Dispo	osition (Name of matory or other		Date	20c. Location - City of	or Town, State
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Division (To the Hospital or Attending for thin 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	ation and/or i	nvestigation, in r	ny opinion, death occ	curred at the time	e, date and place, and d	ue to the cause(s)
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		30. Name and address of person who co	moleted cause of death /Ite	m 23a) (Tvoe	Print)	177/0/	1	April 2	-> , 4005-
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Physici	an	For State Registrar 1. Decedent's Name (First, Middle, Late		aryland / Depa <i>Ce</i>	rtificate of L		2. Date of De	Reg. No.	3. Time of Death
/Medic Examin	al	AGNES 4a. Facility Name (If not institution, give	10		4b. City, Town, or		APIZI	4c. County of De	6 101 80 AM
Funeral Director		022-24-2280		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	U. Dato of Dif	y, Year)	irthplace (State or Foreign Country) assachusetts
aryland show)r	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
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id ZIZIO-0000 e filed within 72 hours af al Hygiene. other than "natural", or vent, the Madical Exem	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12) 1.2	lucation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, nemaker	luring most of we	orking	16b. Kind of Busines	,
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2.0 Sta Registr	100	30. Name and address of person who of Mulugara Fig. 31. Date filed (Month, Day, Year)	SMA MA	Torns for Signature	Print) Hopkins H	los PITAL	600 N.V	NOLFEST,	nth, Day, Year) P.G., 2005 BALTIMARE 2121

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Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	 Place of Injury - At home building, etc. (Specify) 	, tam, str	eet, factory,	office		2	City or Tov		er or Hura	i Route Number,
	spital		29a. Certifier Certifying Physicia	an: To the best of my knowle	dge, death	occurred a	t the time	e, date and	place, a	nd due to the	cause(s) and ma	anner as st	ated.
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	(Check only 2 Medical Examiner: one)	On the basis of examination and manner stated.	and/or in	vestigation, i	in my op	inion, death	h occurre	d at the time,	date and place,	and due to	the cause(s)
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	/			30. Name and addre	ss of person	laver	CI	tre	Print) Dr	. D:		Juli	43	103	>			
State Registrar 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar APR 2 7 2005	÷.					2005 See	egistrar's Signa	ature 🙋		·								

Wanda Marie Copeland

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			1 - For State Registrar	State of M	aryland / Depa		of Health a of Death	nd Mental	Hygier	200)5	15964
	Dhunini		Decedent's Name (First, Middle, Last)					2. Date Mon	of Death	Day	Year	3. Time of Death
	Physici /Medio		Wanda Marie	Copela				04			2005	м
	Examin	er	4a. Facility Name (If not institution, give substitution Hospita)		wn, or Location of kton	Death		4c.County Ceci]		
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. last birthday)	If Under 1 Y	ear If Under 2	4 Hrs. 8. Date	of Birth		9. Birthp	ace (State or Foreign
	Director		158-60-5258	M 2□ X F	44 Yrs.	Months D	ays Hours	Min. 127	09/1	60	New	Jersey
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					1	0d. Inside City Limits
	Maryi f sho	ō	MD Cecil		Elkton							1 ∑ Yes 2 □ No
	28a-	Director	10e. Street and Number			10f. Zip Co	de		10g.	Citizen of V	Vhat Coun	try?
	ours after death with the Maryland rei', or Items 23e or 28e-f show Exertiret must be neithied at	al Di	14 Maple Court			219	921		Un	ited	Sta	tes
		Funeral	11. Marital Status	2. Was Decedent Armed Forces:	Ever in U.S. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)		e - Americ k, White,	
36	hours after lural', or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 XX If Yes, Give	No	1 ☐ Yes 🏖					Blac	
00	"netural",		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual O	ccupation		16b.	Kind of Bu		
15		piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or	(Give	kind of work a DO NOT use r	lone during most etired)	of working				
212	d within giene.	Completed	12	0		itres	5		Re	estau	ıran	<u> </u>
pu	be filed ttal Hygie id other	Be	17. Father's Name (First, Middle, Last) Theodore Wat	rina				's Name (First, M	·	en Sumam	e)	
yla		ဥ			405 Maili	- Add (0)		jie Chi			Chair Tin	Codel
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type Angelia Copelar				reet and Number e Ct. E					Code)
ē,	permit. Pages 1 and 2. Department of Health at Importent: If item 27 is eny injury or other treuong.		20a. Method of Disposition		20b. Place of Dispo	sition (Name o	of !	Date		Location -		wn, State
OE	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ Re 3 4 □ Donation 15 □ Other (Specify)	moval from State	Silverbr			5/2/2	005	Wilm	ingt	ton, DE
Baltimore,	mit. I partm portei y inju		21. Signature of Juneral Service License	9	22	. Name and A	ddress of Facility		201 N	l. Gr	ay I	lve.
m	Depar Depar Impor eny ir			M	00861 C	ONGO 1	FUNERAL	HOME	Wilmi	ingto	n, I	DE 19805
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that cause cause on each l	d the death. Do not ent ine.	er the mode of	dying, such as c	ardiac or respira	tory arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Cox	voe c	me:	x					Onset and Death
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99)	artifica ing ph e as ti	0	IF FEMALE:									
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0	the de	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death 5	Other (specif	y)		_			
P.O.	requires that the death certificent is signed by the attending frould be detached for use as	/ Ph	Part II. Other significant conditions cont	ributing to death b	out not resulting in the u	nderlying caus	e given in Part I.	23e.	Did tobacc	o use contr	ibute to th	e cause of death?
ds	v requires been sign should be	q p	= HIY						1 🗌 Yes	2 🗆 No	3 🗌 Proba	ably 4 Unknown
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Re	o - g	шо							autopsy performed? Yes 2 2 1	ppsy prior to completion of cause of death?		
ta	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check				
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o L			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Dite of Inju (Month, Da			Injury at Work?		cribe how in	jury occurre	ed	
Sio	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of In	ius. At home form str		1 ☐ Yes 2 ☐ N		tion /Street	and Numbe	r or Ruml	Route Number,
Division of	or Al after o Dirac	Certification;	4 Homicide determined	building, el	jury - At home, farm, str ic. <i>(Specify)</i>	eet, factory, or	rice		or Town, Sta		n or nurar	House Mulliber,
	spitel cours neral filled		29a. Certifier 1 Certifying Physi	cian: To the best	of my knowledge, death	occurred at the	ne time, date and	place, and due to	o the cause	(s) and mar	ner as sta	ated.
	To the Hospitel or Attent within 24 hours after deatt To the Funeral Diractor: completely filled in by the	Medical	(Check only 2 Medical Examin one)	er: On the basis of and manner st	of examination and/or inv	estigation, in	my opinion, death	occurred at the	time, date a	nd place, a	nd due to	the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier	1.			cense number		29d. E	ate signed	(Month, E	lay, Year)
			Coperto	IMIZ	- A	DC	0060	+26	4	127	102	
	\		30. Name and address of person who con		death (Item 23a) (Type,	Print)	2 (110	nen	Stree	ef.	W	, BILLON
	-01-	• •	31. Date filed (Month, Day, Year)	3. Registr	rar's Signature		3 00 1	# P== 1 1 3				
	Sta Registr		APR 2 8 2005	Blanc	rar's Signature	de la						

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29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	no	ding h. After fune	tion	1 Natural	5 Pending	(Month, Da		y Wo	ork?	280. Describe not	w injury occurred	a	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar APR 2 8 2005 D000 5 6 9 7 04/25/2005 8/18 60 8/1 Welk Fed Month 20706		To t To t	Σ	29b. Signature and	title of certifier						/	(Month, Di	ay, Year)
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State Registrar APR 2 8 2005 Registrar APR 2 8 2005	1	(10)		30. Name and addr.	ess of person who	- 1/1	110	e, Print)	2 6 1	(unde	- 1-1	6	nham
Registrar APR 2 8 2005 Rom & April		Sto	0	31. Date filed (Mon	th, Day, Year)	3 Regist	rar's Signature	011	0000	337	res	n	20706
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 16ay Jean Koebley Cochran 2005 2:30a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartfields at Easton Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□M 2√□F 212-24-8311 83 Director Vrs 6-11-1921 Warren. Pa Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits raumatic evant, it e Mudical Examiner must be notified at Md Talbot St. Michaels Director 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24659 Long Haul Farm Rd. or Itema 23a 21663 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after of Hygiene.

Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If itam 27 is marked other that any injury or other traumatic access. 12 years
17. Father's Name (First, Middle, Last) Home years Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Be Edwin Koebley Zora Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Strausburg (daughter) P. O. Box 657, St. Michaels, Md. 21663 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 □Donation 5 □ Other (Specify) Capitol Crematory 4-18-2005 Dover, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC Carrols P. O. Box 518, St. Michaels, Md. 21663 nter the mode of dying, such as caldiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as a conseque the burial-transit Hospital or Attanding Phyaiclan: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 21 No Be Completed 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 INO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: Certification; To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Natural 5 Pending after death. death. investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide vithin 24 hours of the Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifiers 0 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

3 Registrar's Signature

MD., 508 Idlewild Ave., Easton, Md. 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert B. Sanchez,

31. Date filed (MPRPa1 Y91) 2005

		·	1 - For AMEND#12 4/26/05 State Registrar AACO HFALIIH D	State of Mai		partment of Fertificate of			iene _{eg. No} 200	5 15967			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ADRIT						Day 20, 200	3. Time of Death 3:00p M			
	Examin	ier	4a. Facility Name (If not institution, giv ANNE ARUNDEL MEDI	e street and number) CAL CENTER		ANNAPO	r Location of Dea LIS	th	ANNE A	ANNE ARUNDEL			
	Funeral Director		5. Social Security Number 216–34–3919 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthda 67 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		γ _{θαr)} , 1937). Birthplace (State or Foreign Country) Maryland			
	Maryland -f show	tor	10a. State 10b. County Maryland Anne A		10c. City, Town or		napolis		10d. Inside Ci 1 Ճ Yes				
	h with the 13a or 28a st be not	ai Direc	10e. Street and Number 110 Lafayette Av	enue		10f. Zip Code	21401	1		g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White			
036	s I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I fleathth and Mental Hygiene. I fleath 71 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinations to notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes The It Yes, Give Year or Dates: 1	-	B. Was Decedent of H If Yes, specify Cuba 1 Yes 2XNo	ispanic Origin? (an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	Black,				
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	1 and 2 sho Health and ! iem 27 is ma		19a. Informant's Name/Relationship (Mary K. Conroy/w						Number, City or Town, State, Zip Code) Dapolis, Maryland 21401				
Baltimore,	0 0 = 5		20a. Method of Disposition 1 ☐ Burial 25 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specia			position (Name of ematory or other place re Cremato	ory 4/2	Date 26/2005	20c. Location - Ci Baltimo:	ty or Town, State re, Maryland			
Balt	permit. Pag Department Important: I any injury o	21. Sign time of Funeral Service Licensee 22. Name and Address of Facility John M. Ta											
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. Box 68/60,	death certificate be executed attending physician and ed for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	Due to (or as a consequence of): d						23d. Date of delivery Month Day Year			
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Division of Vital Records, P.O or Attending Physician: The law requires that the		Completed							y prio ned? dea l No 1	re autopsy findings available or to completion of cause of th? Yes 2 \sum No			
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best of niner: On the basis of each manner state	xamination and/or i	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	use(s) and mannate and place, and	er as stated. I due to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Light no	40	29c. Licenso	e number	29	APRIL 2	Month, Day, Year) 21, 2005			
	Sta	te	30. Name and address of person who THEOWNE MIKENE 31. Date filed (Month, Day, Year) APR 25		th (Item 23a) (Type s Signature		Penn Str	eet Balt	imore, M	Maryland 21201			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2005 April 20, 2:12 John B. Dickman, III pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chevy Chase Montgomery Manor Care 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Davs Hours 1 ☐XM 2 ☐ F Yrs. Nov.30, 1919 Director 758.18.7316 Washington DC Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Marylend nent of Health and Mental Hygiene. and them 27 le marked other than "natural", or Itams 23s or 28e-1 show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No DC Washington **Funeral Director** 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 20008 3628 Veazey Street, N.W. U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No WWII If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Patent Agent Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Bernard Dickman, II Alvina Ruck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3940 Langley Court, N.W. WDC Betty Tolbert/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Importent: If any injury or once. Mt. Olivet Cem. 4/25/05 Washington D.C. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Avenue NW WDC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LIVER DISTABLE Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) CANCER OF AANCIZEAS. Examiner ADVANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS SYNDROME, PNEUMONTA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown MALNUTRITION. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 30 No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Warsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Injury 1 Natural 5 Pending s after dea...-el Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R. Juyan Sundan D53367 04/21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAMIUMDAR, RAJAN; 10810 DARNESDWN RUAD, SUITE: WZ GAITHENSAUG, MI: 20878. 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 8 2005 Registra

DHMH 17 Rev 1/2001

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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent		Feb. 28, 19	928 Mary	land
	tryland show	_	10a. State 10b. County 10c. City, Town or I	Location		1	Od. Inside City Limits
	the Ma 28a-f s	Director	Maryland Queen Annes Church 10e. Street and Number	Hill	· · · · · · · · · · · · · · · · · · ·		1 Yes 2 No
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9-0	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show ha Madical Examinar must be multihed at	ted !	15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b.	B1 Kind of Business/Ind	ack
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d 2	filed w Hygie other th		12 Corr	ectional Office 18. Mother's Name (Baltimore	City
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Maryland 21215-0036	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural		y or Town, State, Zip	Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be indiffed at once.		1 Denoting 5 Community of the Community	ematory or other place)		Location - City or To	
alti	permit. Departm Importe any inju	ı	Citester	field Cem. 04-30-		entreville	
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		Completed			autopsy performed? 1 Yes 2 N	prior to com death?	pletion of cause of
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ō	ding Phys	- To	27. Manner of Death 28a. Date of Injury 28b. Time of		5 Residence d. Describe how inju		
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Division of	or Attend after death Director: A In by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f	f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
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	To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, D	ay, Year)
			30 Norman Ja M. O.	D25849	9	1/25/0	5
			30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number D 2 3 8 8 9 Print) 3 3 H Sh Sheet, Ch	enterte.	on Will	2/620
	Stat		31. Date filed (Month, Day APR 2 8 2005 Registra Signature	1000		- Fred	
	Registra	ır		Anna S.			

Amended, 31, TCH **Physician** /Medical Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or items 23e or 28a-f ehow any injury or other traumetic event, the Medical Examinat must be redified ut apnear. Director

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ın al	William Edward Dobson	Jr.			April 2	7 20	005 121 × M
er	4a. Facility Name (If not institution, give street and number)	,	4b. City, Town, or	Location of Death	′	4c. County	of Death
	The Memorial Hospital		E	astun		10	Ubot
	5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country)
	215-20-2316 90 Usual Residence of Decedent	113.			09 -04-	-1914	Maryland
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erai	221 Glenwood Ave. 11. Marital Status 12. Was Decedent Ever in U.	S. 13.1	21601 Was Decedent of His	spanic Origin? (Spe	acify Yes or No-	USA 14. Rac	ce - American Indian,
Ë	Armed Forces? 1 □ Never Married 2 🏋 Married 1 □ Yes 2 📉 No		f Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)	Blac	ck, White, etc.
ģ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1☐ Yes 2█ No	Specify:		Specify	y: Black
eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done di	uring most of worki	ing 16	b. Kind of B	usiness/Industry
Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+)	Schoo	00 NOT use retired)	-	יו	'allba	t Co. School
ပိ	17. Father's Name (First, Middle, Last)	ВСПОО			(First, Middle, Ma		
To B	William Edward Dobson, Jr.			Carrie	Copper		
—	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a			City or Town,	State, Zip Code)
	Elizabeth Dobson / Wife	221	Glenwood	Δ170 F20	ston Mary	land '	21601
	20a Method of Disposition 20b. P	lace of Dispo	sition (Name of				- City or Town, State
	1 MBurial 2 Cremation 3 Hemoval from State	=	matory or other place Cemetery		-2005 E	acton	,Maryland
	21. Signature of Funeral Service Licensee	the state of the s	2. Name and Address	of Facility			, nary rand
		=	Bennie S 426 Dove	mith Fund r Street	eral Home . Easton.	Marvla	and 21601
	23a. Part1. Enter the disease, or complications that caused the death	n. Do not ent					Approximate Interval Between
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- L		C .	E.		Onset and Death
	disease or condition resulting in death) Due to (or as a consequence)		n In	Jave			_
	500 to (0. 20 2 50.1054	201100 01).					
er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions).	uence of):					
min	cause. Enter Underlying Cause (Disease or injury that initiated events C						
Examiner	resulting in death) Last Due to (or as a consequence)	uence of):					
ā	d						
ledi						1	
an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Feta		∃Ectopic pregnancy				ite of delivery
ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	eath 5	Other (specify)				,
Ph	Part II. Other significant conditions contributing to death but not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use cont	tribute to the cause of death?
d by					1 ☐ Yes	2 🗆 No	3 Probably 4 → Triknown
pieted by Physician/Medic					24a. Was an autopsy	24b.	Were autopsy findings available prior to completion of cause of

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760,

Pnysician /Medical Examiner

William E. Dobson

Physician/Medical Examiner Be Completed by Medicai Certification: To

performed (Yes 20 No 1 ☐ Yes 26. Place of Death (Check only one)

1 Yes 2□ No

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 27. Manner of Death

Impatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 28b. Time of

Other: 4 🗌 Nursing Home 3□ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

4 THomicide

29c. License number 00053 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington Street, Easton, Maryland 21601 219 S. Dr. Dennis DeShields,

State Registrar

31. Date filed (Month, Day,

APH 2 8 2005



(0)

			For State Registrar	State of M	arylanc	-	artment of I		and Me		iene	005	15971
			1. Decedent's Name (First, Middle,	_ast)					2	. Date of Deat Month	h Day	Voor	3. Time of Death
Н	Physici /Medic		Bernard	Joseph	Dru	ıry,	Sr.			April	28.	Year 2005	10:10 p.m
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location o	f Death		4c. C	ounty of Death	3
			26750 Three Not					hanics				St. Mar	
	Funeral			. Sex 7. Ag 1 ■ M 2 □ F	ge (In yrs. la	ist birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthp Cour	lace (State or Foreign htry)
	Director		213-16-2687 Usual Residence of Decedent		85	115.				Jan. 29	,192	20 Mary	land
	land ow		10a. State 10b. County		10c. City,	Town or Lo	ocation					1	0d. Inside City Limits
	Mary f sh	ō	Maryland St.	Mary's			Мо	chanic	. o. r i 1 '	1.0			1 ☐ Yes 2 💹 No
	288	Je.	10e. Street and Number	Haly S	1		10f. Zip Code	Chanic	SVII		0g. Citize	en of What Cour	ntry?
	3a or	0	26750 Three Not	ch Road			2	0659			_	ed Stat	
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent		. 13.	Was Decedent of H		gin? (Speci			4. Race - Americ	an Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 271a marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Modical Exactination and be conflicted.	by Fur	1 ☐ Never Married 2 ♣ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		i	If Yes, specify Cub 1 ☐ Yes 2 🖀 No		, Puerto Ri	can, etc.)	S	Black, White, Specify:Whit	
ŏ	2 hou	ted	15. Decedent's			16a. Dece	dent's Usual Occup	pation			16b. Kind	d of Business/Inc	dustry
7	hin 7.	Completed	(Specify only highest (Secondary (0-12)	College (1-4or	54)	(Give life.	kind of work done DO NOT use retire	during most d)	of working	'			·
2	d with	МO	Elonionally Coloridaly (5 12)	1	31)	Elect	rical Co	ntract	or		Co	nstruct	ion
þ	at Hy other vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mothe	r's Name (i	First, Middle, M	Maiden S	iumame)	
<u>a</u>	should be nd Mental marked o	To	Francis Euge	ne Drury					Eliz	abeth	Long		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumstic event, It a M.		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numbe	r or Rural F	Route Number,	City or	Town, State, Zip	Code)
	l and 2 lealth m 27 I		Betty A. Drury	/ Wife		26750	Three N	otch R	Road.	Mechan	icsv	ille, M	D 20659
ore	of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Demoust from State	1 001	ace of Dispo	sition (Name of matory or other pla		Dat			ation - City or To	
Ĕ	Pages nent of h ant: If ite ury or of	- 2	*4 □ Donation 5 □ Other (Spe			n of	Peace Ce	m. 5	5-5-20	005	Hele	n, Mary	land
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service L	1	M000	22	2. Name and Address	ess of Facility	Brin Road	sfield	Fun	eral Ho	me, P.A. 20650-0279
			23a. Part1. Enter the disease, or co	emplications that cause	d the death.							W11 - 11D	Approximate
			shock, or heart failure. List or Immediate Cause (Final	ly one cause on each i	iiie.		1.19	e 1.	is None			10	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as	a conseque	ance off:	- mgr	te	ng			10	nte
	Examiner		1				1		0			1	
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of):							
	cate be executed chysicien and the burial-transit	Examine	Cause (Disease of injury that initiated events	c.									
Ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):							
8760,	ysicie ysicie	dicai		d									
9	tifica ig ph as th	led									-		
Вох	The law requires that the death certifics to has been signed by the attending pt bage 2 should be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1⊟Live birth			Ectopic pregnanc				23	d. Date of delive	ry
<u>m</u>	deati e atte	icia	in the past 12 months?	4 ☐ Pregnant a			Other (specify)	y 			-	Month	Day Year
P. O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown									
S, F	w requires that been signed by should be det	УР	Part II. Other significant conditions	contributing to death b	out not result	ting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use	e contribute to th	e cause of death?
ĕ	quire an sig		COPD							1 ☐ Ye	s 2 🗆	No 3 1000	ably 4 Unknown
Record	aw re	Completed								24a. Was ar		24b. Were autor	osy findings available
	The lav le has age 2	E C								autops	ged?	death?	npletion of cause of
Vital	ician: Th certificate rector, pag	a)	25. Was case referred to medical					26 Place	of Death //	1 ☐ Yes 2	146	1 🗆 Yes	2000
5	/sicil	To B	examiner? 1 ☐ Yes 2 ☐	Hospital:	ent 2∏F	R/Outpatier	it 3 DOA Ott		sing Home			Other (Specify	d
ō	Phys er this eral di		27. Manner of Death	28a. Date of Inju	iry 2	28b. Time of	28c. Injui	v at		Describe ho)
Division of	th. : Afte	tio	2 ☐ Accident 5 ☐ Pending investigat	(Month, Da	y Year)	Injury	M 1 🗆	rk? ∣Yes 2.∐.N	No				
/ISI	or Attending Physician: after death. Director: Atter this certifici in by the funeral director, i	Certification:	3 ☐ Suicide 6 ☐ Could not	ad 289. Place of In	jury - At hom	ne, farm, str	eet, factory, office		281	f. Location (Str	eet and	Number or Rural	Route Number,
á	after after Dire	ert	4 Homicide	building, et	c. (Specify)					City or Town	, State)		
<	To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o	of examination	ledge, deatl on and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and h occurred	d due to the ca at the time, da	iuse(s) a ate and p	nd manner as st lace, and due to	ated. the cause(s)
)	To the Ho within 24 to the Fu Completely	Mec	29b. Signature and title of certification	That it of st			29c. Licens	e number		29	d. Date	signed (Month, L	Day, Year)
	F≯Fö			(7		5/	4/00	
r					dab #*			991	/		3/	1 - 3	
			30. Name of address of power wh	0.00			•		٠.	3.6	- 51	1 00616	
	a white	-	James C. Boyd, 31. Date filed (Month, Day, Year)		5 Thr		tch Road,	Cali	torni	a, Mar	ylan	a 20619	
	Sta Registr		NAY 0 4	2005	Li S Sigilatu	K 1	الكامون						
DH	MH 17 Rev 1/2		0.0 0.0 Jan			-7	7						
				The same of the sa									

ORIGINAL

			FOR	Maryland / Dep	artment of He	ealth and Me	ental Hygie	ne	E Prote also more as
			State Registrer	Ce	rtificate of D		Reg.	NG: UU5	15972
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Eppa Hunton Diedrich 4a. Facility Name (If not institution, give street and num.)	ber)	4b. City, Town, or I		April 22	, 2005 4c. County of Dea	11:20 A M
	Examin	er	Anne Arundel Medical Cent		Annapo			Anne Aru	
	Funeral Director			. Age (In yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Ye 11-01-1	9. Birl 926 Vi	hplace (State or Foreign ountry) rginia
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla 1 aho	tor	Maryland Anne Arundel		vidsonvill	.e			1 □Yes 2 🛣 No
	or 28a	irec	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Co	ountry?
	ath wit	raiD	1139 Old Davidsonville Ro		210			USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-1 ahow other traumatic event, the Medical Exam for must be notified at	y Funerai Director	Amed Ford 1 □ Never Married 2 ▼ Married 1 ▼ Yes 2	2 □ No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	hours tural;	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Date 15. Decedent's Education	es:W.W. II	dent's Usual Occupa	tion	161	o. Kind of Business	
215	nin 72 In "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give	kind of work done di DO NOT use retired)	uring most of working	7	5. Turid or Edonio 3d	ddd.i.y
21	filed with Hygiene. other than	Com	12th		echanic			Automoti	.ve
Maryland	lbe fill ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)	i ah		18. Mother's Name (^{First, Middle, Mai} fie Pear		
Z Z	2 should be and Mental is marked c	ဥ	Charles Henry Diedr: 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a				Zip Code)
	1 and 2 s Health ar tem 27 is		Laura W. Diedrich/ Wife						e, MD 21035
Baltimore,	Pages 1 a nent of Her int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	20b. Place of Dispresentate	matory or other place			c. Location - City or	
İţi	perr it. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee		Crematory 2. Name and Address			dgewater, Kalas Fur	mD meral Home
B	Dep Imp any		Muto Clab-	la la	2973 Solom				
	Pnysician		Part . Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	ch line.	ter the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death WEEK J
	/Medical Examiner		resulting in death) Due to (or	r as a consequence of):	EUMONI	Δ			DAYS
	14 14 1	er	Sequentially list conditions, if any, leading to immediate b. Due to (co.	r as a consequence of):	Lunioni	~			QH112
	cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initialed events.	URI	NARY	TRACT	INFE	TION	WEEKI
,09,	cate be executed physician and the burial-transit	ical Ex	resulting in death) Last Due to (o	r as a consequence of): REM	VAL F	ALLULO	=		WEEKS
68760	ificate g phys as the		d	700					22
Box.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	nt at time of death 5	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of de Month	ivery Day Year
ds, P.O.	uires that the de signed by the a id be detached f	þ	Part II. Other significant conditions contributing to dea		inderlying cause give	n in Part I.	23e. Did tobac		o the cause of death?
Records,	s been si	Completed	ENCEPHALD SEPTIL ATH	RITIS			24a. Was an	24b. Were au	itopsy findings available
Re	The la	omo					autopsy performed	d? death?	completion of cause of 2 No
Vital	cian: ertifică actor, p	Be	25. Was case referred to medical examiner?		100	26. Place of Death			
of \	ding Physician: The lav h. After this certificate has funeral director, page 2	-T		patient 2 ER/Outpatie		4 Nuising Home	e 5 Residenc	e 6 Other (Spe	cify)
O	ding After fune	tion	27. Manner of Death Natural 5 Pending Accident investigation 28a. Date of (Month)	, Day Year) Injury	Work	? 'es 2 \(\text{No} \)	d. Doscribo riow	injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	28	8f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	ours a		29a. Certifier Sertifying Physician: To the	pest of my knowledge, dea	th occurred at the time	e, date and place, an	nd due to the caus	e(s) and manner as	s stated.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medicai	(Check only one) 2 Medical Examinar: On the ba	sis of examination and/or in	nvestigation, in my op	inion, death occurred	d at the time, date	and place, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier		29c. License			Date signed (Mont	
			> 1/5 W D			514 37		0	4/22/05
_			O DARLY IBLINYE	AAMC	ANKAP	olls n	10 21	401-	2777
	Sta Regist		31. Date filed (Month, Day, Year) APR 2.5 7008	distrar's Signature	Like				
			7						

			1 - For State Registrar			d / Depa		t of H	ealth a	and M	lental Hy		0.05	150	7.2
			Decedent's Name (First, Middle	, Last)				-			2. Date of Dea	ith		3. Time of De	ath
	Physici		ZOE VOUZIKAS	DeFONZO							Month April	Day 24	Year 200	0 00	A М
1	/Medio		4a. Facility Name (If not institution		nber)		4b. City,	Town, or	Location of	of Death	Whiti		ounty of Dea		
			Casey House				Roc	kvil	lle			M	ontgo	nery	
	Funeral		5. Social Security Number		7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)	9. Bi	rthplace (State or Fo	oreign
н	Director		579.40.4316	1□M 2⊠F	77	Yrs.	Wichars	Days	fiours	WINT.	Sept.12	19		shington, l	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City L	imite
	sho	5		om o Kii	1	nsingt								1. Yes 2[
	288-1	Director	Maryland Montg	omery	I/C		10f. Zip	Codo				10= Chin-	en of What C		
	with with	ä										_		ountry :	
	ns 23	by Funerai	4301 Knowles A		dent Ever in U	.S. 13.		0895 lent of Hi	spanic Ori	gin? (Spe	ecity Yes or No-		Race - Am	erican Indian,	
10	r iten		1 Never Married 2 Marri	Armed For	rces?		If Yes, spec	rfy Cuba	n, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh		
036	el', o	b	3	If Yes, Giv Year or Da			1 ☐ Yes 2	2 X No	Specify:			S	pecify: W	hite	
2-0	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show the Madical Exemple must be indiffied at	Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usua kind of wor	al Occupa	ation	t of work	ina	16b. Kind	of Business	s/Industry	
2	ithin	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired)	. 0. 11071.	9				
7	ygier ygier her th	S		l yea	r	Se	ecreta	ary						ernment	
pu	be fil Ital H Id off	Be	17. Father's Name (First, Middle, I	ızikas							(First, Middle,	Maiden Si	umame)		
yla	Mer Mer Marka Marka	은				T					Lynard				
Maryland 21215-0036	12 st h and 7 is n traum		19a. Informant's Name/Relationsh Alexander Vouz		h		-				Al Route Numbe	-			
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then. "nature!, or Items 23a or 28e-1 show amportent: If item 27 is marked other then." and it is marked other the marked of a nature is not item. Items 23a or 28e-1 show approach 17 in Items 23a or 28e-1 show approach 17 in Maryland 18 in		20a. Method of Disposition	IKAS/BIOL		Place of Dispo			1111		, Gardn			40-2316 r Town, State	
יסר	S T T S		1 Burial 2 ☐ Cremation		State	emetery, crei	matory or o	ther plac							
Baltimore,	it. Partment of the night.		* 4 □ Donation 5 □ Other (S _I 21. Signature of Funeral Service I		CEO	lar Hil								Maryland	
Ba	Depa Impo		A A		t.	Ħ	INES-	RINA	LDI	UNE	RAL HOME	IN IN	C.	ing, MD 20	0004
			23a. Part1. Enter the dilease, or	complications that ca	aused the deat								r spri	Approximate	
	Dhusisian		shock, or heart failure. List Immediate Cause (Final			D								Interval Betwee Onset and Dear	
	Physician /Medical		disease or condition resulting in death)	a	eimer's orasaconseq		se							Months	
	Examiner					201100 011/1									
		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonseq	uanda of):									
	cuted nd ransit	Examiner	that initiated events	c											
0,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):									
8760,	<u> </u>	licai		d											
68	leath certifica attending ph i for use as th	Med	IF FEMALE:			707							_	1	
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	Ideath 3	Ectopic pr	egnancy				23	d. Date of de	elivery Day Year	
0.	at the dea by the a tached for	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregn: 9□ Unkno	ant at time of down	eath 5	Other (sp.	ecify)					Mortan	Day 18a1	
Ρ.	that the	Ph)	Part II. Other significant condition	ns contributing to de	ath but not ree	ulting in the u	nderhing o	ausa aur	on in Part I		23a Did to	hacco use	contribute t	to the cause of death	h2
Records,	98	l by	Tarris official offic	ing contributing to de	au but not res	uiting at the d	noonlying G	ause give	minirani.	•				robably 4 DUnkr	
Ö	w require been si should b	ompleted									-				
3ec	has I	Idm									24a. Was a autop	sy		utopsy findings avai completion of cause	
		O									1 Yes		1 ☐ Ye	s 2 No	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			-	Othe			(Check only or			TT	
of	Phys this ral di	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 1		28b. Time of		A	4 🗆 140	-	me 5 Resid 28d. Describe h			ecify) Hospi	Lce
	Attending Phore of death. actor: After this by the funeral	ertification;	1 XNatural 5 ☐ Pendin		of Injury h, Day Year)	Injury	м	8c. Injury Work	ເ?ີ່ Yes 2.∐i		Lou. Describe II	OW IIIJuly (occurred		
Division	I or Attendi after death. Diractor: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could r	ot be 290 Place	of Injury - At he	ome, farm, str					28f. Location (S	treet and l	Number or F	Rural Route Number,	
Θ	after Dira Jin b	erti	4 Homicide determ	buildir	ng, etc. (Specif	y)	,,	,			City or Tow	n, State)		,	
	spitel	aic	29a. Certifyin	g Physician: To the	best of my kno	wledge, deat	h occurred :	at the tim	e, date an	d place,	and due to the o	ause(s) ar	nd manner a	s stated.	
	To the Hospitel or A within 24 hours after To the Funerel Diracompletely filled in by	edicai	(Check only 2 Medical one)	Examiner: On the ba and mann	asis of examina	tion and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time, o	late and p	lace, and du	e to the cause(s)	
	withir To the	ž	29b. Signature and title of certifier				29c	. License	number		2	9d. Date:	signed (Mon	th, Day, Year)	
	10		I Chrilie Cy	my				BR -	42161	14	A	pril	24, 2	.005	
			30. Name and address of prion					7.5			-	-			
_			Chitra Rajago	pal, MD, 6	5001 Mu	ncaste	r Mil	1 Ro	ad, F	lockv	ville, M	D 208	855		
	Sta		31. Date filed (Month, Day, Year)	7 2005	gistrar's Signa	itura de	men								
	Registi	ar	APR 2	7 2005 🔝	manes -	~ //									

05-2826 RJD Albert Do:

rt	Donnel:	Ly	1 - For State Registrar	State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	ne 2005	15974
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Media		Albert Eugene Dor					2325P. ™
	Examir	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
			Montgomery General 5. Social Security Number 6. Se		Olney y) If Under 1 Year If Under 24 Hrs.		Montgomery	
	Funeral Director			7. Age (In yrs. last birthda M 2 F 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
			Usual Residence of Decedent			Nov. 4, 1	.919 New	York
	yland		10a. State 10b. County	10c. City, Town or	Location		1	10d. Inside City Limits
	Mar B-f sl	itor	Maryland M	ontgomery	Silver Spri	ng		1 ☐ Yes 2 No
	th the	ire.	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
	within 72 hours after death with the Maryland ans. then "neturel", or items 23s or 28s-f show the Madical Examiner must be notified at	Funeral Director	3669 Edelmar Ter	race	20906	1	USA	
	r dea	inei	11. Marital Status	12. Was Decedent Ever in U.S. 13 Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No-	14. Race - Americ Black, White,	
36	or Ir	by Fi	1 Never Married 2 Married	1 A Yes 2 □ No If Yes, Give 1939 - 79 Year or Dates:	1 ☐ Yes 2 № No Specify:		Specify:Whit	
8	hour turel	g p	3 Widowed 4 Divorced			1.40		
5	n 72	ete	15. Decedent's Edu (Specify only highest grad	completed) (Giv	cedent's Usual Occupation we kind of work done during most of work o. DO NOT use retired)	king	. Kind of Business/In	dustry
21215-0036	withi ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	b Tech./Military O	fficer E	lectrical/	II S Army
	filled Hygi other	60	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai		O.S. Almy
an	id be ental ked c	ToB	Edward J. Donne	lly	Ma	ry Link		
Maryland	should be filed within and Mental Hygiene. s marked other then " sumatic event, I'm Mes	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Ma	iling Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, Zip	Code)
	and 2 salth a n 27 ls		Dorothy L. Donnel	ly/ Wife 366	9 Edelmar Terrace,	Silver Sp	pring, MD	20906
Baltimore,	- T & 5		20a. Method of Disposition		position (Name of rematory or other place) July	Date 200	. Location - City or To	own, State
E	Pages nent of I ont: If Its		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	amovai irom Stata I	National Cemetery 200		ington, V	irginia
ati	permit. Departm Importe any inju		21. Signature of Funeral Service License	90 / F	22. Name and Address of Facility	Funeral H	Ome Inc	
8	80 E 2 8		The S. X	Scere 5	22 Name and Address of Facility Fancis J. Collins 600 University Blvc	W., Sil	ver Spring	, MD 20901
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	nics			Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 6	that the death certific led by the attending p detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		B □Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that been signed to should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th 2 ⊠No 3 ☐ Prob	ne cause of death?
al Records,		Completed				24a. Was an autopsy performed	prior to con death?	psy findings available mpletion of cause of 2 No
Vital	ilcien certifi rector	Be	25. Was case referred to medical examiner?	ospital:		h (Check only one)		
of	Physicien: r this certifica ral director, p	10	1 X Yes 2 No 27. Manner of Death	1 Linpatient 2014EH/Outpati	The same of the sa		6 ☐Other (Specify	y)
U	ting After fune	tion	1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury 22141	Work?	28d. Describe how in		n coursion
Division	Attending or death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s			and Number or Rura	
Β	after Dire	erti	4 Homicide determined	building, etc. (Specify)		City or Town, S.	tate)	ON EDUTO
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowledge, der her: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place	and due to the cause	a(c) and manner ac ct	ated
	To th withir To th	Me	29b. Signature and title of certifier	Λ	29c. License number	29d.	Date signed (Month,	Day, Year)
	- 11		Mounto	The Yould wine	OCME	A	pril 23, 2	005
	10+1		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	Print)			
			MARGARIAS	D. KUREL	111 Penn Stre	et Baltir	more, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year)	32/Registrar's Signature	parke			

			1 - State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygie	4000	15975
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		David Louis Exline		April 30	Day Year	06:00A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Aprili	4c. County of Death	
н	_Admiii		236 W. Main St.	Sharpsburg		Washingt	on
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo	9. Birth	place (State or Foreign
ь	Director		235-50-7010 1 M 2□ F 69 Yrs.	Months Days Hours Min.	July 21,	1935 West	Virginia
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				1011 11 02 11 2
	shov	'n					10d. Inside City Limits 1 Yes 2 No
	he M	ecto	MD Washington Sharpsbur			5:: (1111 1.5	
	with a or i	급		10f. Zip Code	109	. Citizen of What Cou	intry?
	eath ra 23	Funeral Director	236 W. Main St. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ocify Vee or No-	USA 14. Race - Amer	ican Indian
	ffer d r Iten liner	표	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
980	urs a	b	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Specify:		Specify: Whi	te
21215-0036	72 ho	Completed		edent's Usual Occupation e kind of work done during most of worki	16	b. Kind of Business/I	ndustry
21	thin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ing .		
7	ed wi	Col		han ic		[rucking_	
<u>n</u>	fal H d oth	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	,	
₹	ould Men warke	ို	Arthur Dequoy Exline	Willa	LaRue	Canfie	
Maryland	12 sh and 18 m			ing Address (Street and Number or Rura			p Code)
	1 and Healtl em 27 ther t		20a. Method of Disposition 20b. Place of Disp	W. Main St. Sharps		c. Location - City or T	our State
Jou	nf of i: If it		1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State demetery, cre	ematory or other place)			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nullised at ODGe.			Cemetery May 3	The state of the s	narpsburg,	MD 21/82
Ba	Departmine Department of the procession of the p			22. Name and Address of Facility SBORNE FUNERAL HOM Illiamsport, MD 21).Box # 34	8
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition	Conce			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				1. cyecrs
ı	Examiner		Sequentially list conditions. b.				
	sit ad	ine	dany, leading to immediate cause. Enter Underlying Caus. [Usass or injury that initiated events cause.]				
	ecufe and I-tran	Examiner	that initiated events resulting in death) Last C				
8760,	death certificate be executed e attending physician and d for use as the burial-transit		Bus to (or as a consequence or).				
387	icate phys s fhe	dicai	d				
9 X	certif Iding	/Me	IF FEMALE: 23b. Was decedent assented. 23c. If yes, outcome of pregnancy			23d. Date of deliv	
Вох	death certifics attending pl	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Month	Day Year
P.O.		Physician/Me	1 Yes 2 No 9 Unknown				
	requires that the leen signed by th hould be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	w require been sig should b				1 ☑ Yes	2 □No 3 □ Pro	bably 4 Unknown
000	> 13 m	Completed			24a. Was an	24b. Were aut	opsy findings available
Ä	0 - 9	E O			autopsy performed	d? death?	ompletion of cause of
ita	aician: Th certificate irector, pag	BeC	25. Was case referred to medical	26. Place of Death			
	ya Si dii	10	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Hor	me 5 Residenc	e 6 □Other (Speci	fy)
0 0	ng Ph ffer th meral		27. Manney of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how	injury occurred	
sio	Attending r death. actor: Afferoy the fune	catio	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
Division of	Hospital or Attending 24 hours after death. Funeral Diractor: Affer fely filled in by the funer	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number.
	Hospital 4 hours a Funeral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea				
	Ho Fur 4	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	se(s) and manner as s and place, and due t	to the cause(s)
	To the I within 2.	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month.	Day, Year)
			Muchael J. Mulamed M.	0 041667		5.2.	05
	000 - 4		30. Name and address of person o completed cause of death (Item 23a) (Type Michael McCornack 1/1/0 / 31. Date filed (Month Pay Year) 2 2005 32. Registrar's Signature	, Print)			
10	4-4		Michael Mclormack 11110/	nedical Campu-	Besi	ersbun	mo.
	Sta		31. Date filed (Month Pay, Year) 2 2005	1	-		
	Registi	al	Miller B.	golde			

			1 - For State Registrer	State of Mar		d / Depa		t of H	ealth a				005	15976
p-	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La BEUE 4a. Facility Name (If not institution, giv	FREE	EMI	AN	4b. City,	Town, or	Location o		2. Date of De Month	Day 4c.	200 County of Dea	
	Funeral Director		5. Social Security Number 6. S 050-07-8753 Usual Residence of Decedent	ex 7. Age	-	ast birthday) 93 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Feb 5,			nthplace (State or Foreign ountry) W York
9800	72 hours after death with the Maryland naturel, or items 23e or 28s-f show digal Exercinal must be notified at	d by Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 12428 Littleton S 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	Street 12. Was Decedent Every Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Silv	1	ing 10f. Zip 2090 Vas Deced	06 dent of Hi crify Cubar 2₩ No	Specify:	gin? (Spec I, Puerto F	offy Yes or No lican, etc.)	USA - 1	4. Race - Am Btack, Whi Specify: Wh	encan Indian, ite, etc. ite
Maryland 21215-0036	filed within 72 Hygiene. other then "nal ent, I're Medic	Be Completed	15. Decedent's E. (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	College (1-4or 5+)		16a. Deced (Give life. L Medic	kind of wor OO NOT us	rk done d se retired)	uring mosi Lcian		g (First, Middle,	Неа	thcar	
Marylan	2 should and Mer is marke eumatic	ToB	Joseph Freeman 19a. Informant's Name/Relationship (Herbert Freeman/t				~		nd Numbe	r or Rural		er, City or	Town, State,	Zip Code) D 20906
Baltimore, I	permit. Pages 1 and Department of Health Importent: if item 27 any injury or other to		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specific	Removal from State		ace of Dispos metery, crem Arunde	sition (Nan natory or o	ne of ther place	9)	Apri ^D Í 200	ate 27,	20c. Loc	cation - City or	
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Licer Devel 4. H. 23a. Part 1. Enter the disease, or com	elte		251 Be	verly	L.	Heck	rotte	P.A.	Cla	.0. Bor	x 784 le, MD 21029
	Wedical was and burial-transit to burial-transit was burial-transit was a second of the property of the proper	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Least (Lieute of the Image) that intitated events resulting in death) Last	b. Due to (or as a control of the co	consequ	ence of):								Interval Between Onset and Death
.O. Box 68760	death certificate e attending phy d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of de Month	Day Year
Records, P	v requires that been signed should be de	ompieted by PI	Part II. Other significent conditions of	contributing to death but	not resu	tting in the un	derlying c	ause give	n in Part I.			Yes 2	No 3 □ P	o the cause of death?
Vital Re		Be Comp	25. Was case referred to medical examiner?	7					26. Place	of Death	autor	psy prmed? 2 No		utopsy findings available completion of cause of
of	ding Phys h. After this funeral di	ဥ	1 Yes 2 No 27. Manner of Death 1 Notational 5 Pending 2 Accident Investigation			ER/Outpatient 28b. Time of Injury	_	8c. Injury Work	at	21	e 5 🗌 Resid 8d. Describe I		Other (Spe	acify)
Division		I Certification;	3 Suicide 6 Could not be determined	building, etc.	(Specify,)					City or To	wn, State)		ural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only one) 2 Medical Exer	nysician: To the best of miner: On the basis of e and manner state	xamınatı	viedge, death on and/or inv	estigation,	in my op	inion, dea	d place, ar	d at the time,	date and	place, and du	s stated. e to the cause(s) th, Day, Year)
D	2		30. Name and address of person who			23a) (Type, I	Print) 7	100	613	07 4nn	oll,	AVE	1/26 nue	105
	Sta Registr		31. Date filed (Month Ager Prea) 8	2005 32. Rhistrar	s Signat	ure K	1	AK	MME		nv,	MI	My	1tn)

DARVELL GUEST 05-02851 RKD

			artment of Health and Mental Hygiene rtificate of Death Reg. No.	005 15977
Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day APRIL 24,	3. Time of Death 2005 4:08A. M
/Medic Examin		DARVELL R. GUEST 4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL STU		2005 4:08A. M
Funeral Director		5. Social Security Number 214-94-7588 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 25 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 11, 197	9. Birthplace (State or Foreign Country) Maryland
yland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
with the Maryland a or 28e-f show	Director	Maryland Harford	Edgewood	1 ☐ Yes 2 No
th with t		10e. Street and Number 516 Crownwood Court		on of What Country? nited States
ter dea	by Funerai	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Race - American Indian, Black, White, etc.
	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	of Business/Industry
nd 2 I Hygie other i	Be Co	12 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden St	
laryland 212. 2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M.	To B	Jerry Guest	Cheryl Blevins	
re, Maryla s 1 and 2 should f Health and Men Item 27 is marke other treumatic			ng Address (Street and Number or Rural Route Number, City or 7 Kirk Caldy Way, Abingdon, MD 2	
ore, Meath of Health		20a. Method of Disposition 20b. Place of Dispo		ation - City or Town, State
Baltimore, bermit. Pages 1 ar Department of Hea mportent: If Item: nny Injury or other		`4 ☐Donation 5 ☐Other (Specify) Berkly	Cemetery 4/30/05 Dar	clington, MD
Baltimo		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Lisa Scott Funeral Home, P. 1 552 Lewis Street, Havre de (A. Grace, MD 21078
Watcian and Examiner the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	NOT WOUNDS	
9 5 G 2	Physician/Medi		Ectopic pregnancy	d. Date of delivery Month Day Year
cords, P. (**requires that the been signed by should be detact.)	by	Part II. Other significant conditions contributing to death but not resulting in the u		o contribute to the cause of death?
The The page	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☑X es 2 □ No
of Vital Physicien: The Physicien: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No Hospital: 1 □ Inpatient 2 XER/Outpaties	26. Place of Death (Check only one)	
On ding	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 4 1 2 4 10 1 12 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28c. Injury at Work? 28d. Describe how injury of	occurred
DIVISI To the Hospitel or Atten within 24 hours after dear To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office 28f. Location (Street and N City or Town, State)	Number or Rural Route Number, PERLY VILLE, HD
Hospitel 24 hours 3 Funeral etely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat and manner stated.	n occurred at the time, date and place, and due to the cause(s) ar vestigation, in my opinion, death occurred at the time, date and pl	nd manner as stated. lace, and due to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number 29d. Date s	signed (Month, Day, Year)
		Quet -		24, 2005
\		30. Name and address of person who completed cause of death (Item 23a) (Type, ANA RUB (O, HO	111 PENN STREET, BALTIMORE MAR	YLAND 21201
Sta Registr		APR 2 8 2005	uk	

State of Maryland / Department of Health and Mental Hygiene | 1 | 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 23 Edith P. Gray April 2005 4:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Larkin Chase Healthcare Prince George's Bowie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 7, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1 ☐ M 2 😾 F 82 Yrs. Director 577-36-3084 Usual Residence of Decedent the Maryland works 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exactiner count be notified at 1 Yes 2 No Directo Maryland Prince George's Upper Marlboro or 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 208 Kettering Drive 20774 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and teem 27 is marked other then "neturel", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Housekeeping Private event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wicks Augustine Onion treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If item 27 is any Injury or other treuonce. Rudy C. Gray - Son 208 Kettering Dr., Upper Marlboro, MD Date 20c. Location City 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 4/29, 2005 Suitland, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Stewart Funeral Home lu00 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease of condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 4 Warsing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 145217 Name and addres person who completed cause of death (Item 23a) (Type, Print) MAYI MI 6201 GREENBELT AS HUIS COllege Pic Aus 20140 DEBUNALE 31. Date filed (Month, Day, Year) 2. Registrar's Signature. State

Registrar

				epartment of Health and N Certificate of Death		giene 0 0 5	15979
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ith	3. Time of Death
	Physicia /Medic		William Earl Goff		Month April	Day Year 26 2005	12:36A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Deat	
			Prince George's Hospital	Cheverly	,		George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day		hplace (State or Foreign untry)
-	Director		248-09-5907 94 Usual Residence of Decedent		Sep. 4,	1910 Sou	th Carolina
Vand	Mot a		10a. State 10b. County 10c. City, Town	or Location		<u> </u>	10d. Inside City Limits
Ma	a-f st	tor	Maryland Prince George's	Mitchellvi	110		1 Yes 2 ☐ No
th the	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
th.	23a		1716 Albert Drive	20721		United	States
r do	E E	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	rican Indian,
should be filed within 72 hours after death with the Maryland	o H	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes, Give 1 ☐ Yes 2 🔯 No If Yes, Give 2 ☐ Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			erican
3	itural		A	Decedent's Usual Occupation		16b. Kind of Business/	
, i	- u - u - u - u - u - u - u - u - u - u	Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king	TOD. THIS OF DUSINESSA	industry
1	giene ar tha	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Superintendent		Ruildings	& Grounds
1	otha vant,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle,	Maiden Sumame)	_u_urumua
1	Menta arkad atic a	Tof	Adam Goff		Ella Vi	ctoria Brow	n
	and is ma aumi			Mailing Address (Street and Number or Run			(ip Code)
5 5	m 27			716 Albert Dr., Mitc			
Page 1	Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumetic avant, "the Medical Exams or unative or other traumetic avant, "the Medical Exams or unative notified at once."		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or	Town, State
6	rtant:			7	3/2005	Portsmou	
	Depa Impo any ir		21. Signature of fluneral Service Licensee			uneral Home	
			23a. Part 1 Enter the disease or complications that caused the death. Do n	4001 Benning Rd.,			019 Approximate
			23a. Part I, Enter the disease, or complications that caused the death. Do n shock for heart failure. List only one cause on each line. Immediate Gause (Final	or differ the mode of dying, such as dardiae	or respiratory an	1031,	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) Sepsis Due to (or as a consequence of	Δ.			
	xaminer		Decubitus Ulc				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of				
patit	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. Dehydration				
5	sician and burial-transit	EX	resulting in death) Last Due to (or as a consequence of	rf):			
cate he executed	physici the bu	dical	d. Alzheimers Di	sease			
		Mec	IF FEMALE:				
	attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy		23d. Date of del Month	very Day Year
) 2	by the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			,
The law requires that the death certifi	ed by detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
3	been signed be should be detailed	d by			1 U Y	es 2□No 3□Pr	obably 4 Dunknown
	shou	Completed			24a. Was a	an 24b Were au	topsy findings available
1 2	page 2	duc			autop	sy prior to o med? death?	completion of cause of
		a	25. Was case referred to medical	26. Place of Deat			2□ No
Veirl	is certific director,	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Other		lence 6 Other (Spec	c(fv)
5 6	h. After th funeral	n: T	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at hijury Work?		ow injury occurred	
5	feath. tor: Af the fur	atic	2 Accident investigation	M 1 Yes 2 No			
NA P	Oirecto in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (S City or Tow	Street and Number or Ru m, State)	ral Route Number,
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Or National or Attending Physician	within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1	, death occurred at the time, date and place, Dor investigation, in my opinion, death occur	and due to the or red at the time, or	ause(s) and manner as date and place, and due	stated. to the cause(s)
9 6	o tha	Me	29b. Signature and title of Carther	29c. License number		29d. Date signed (Monti	n, Day, Year)
F	s = 0		· 12-C/1.	MD 1010/			
	3		30. Name and address of person who completed cause of death (Item 23a) (MD 12134 Type, Print)		April 26	2005
_()			rving St., N.W. #118	B, Wash.	DC 20010	
	Sta		31. Date filed (Month, Day, Year) . Registrar's Signature				
	Registr	al	APR 2 8 2005				

Please Type or Print in Black Indelible Ink Ensure All

			riease	State of Mar			lealth and M	-	_	e.
			1 - For State Registrar	Olate of Mai		rtificate of			200	5 15980
	Physici /Medic		Decedent's Name (First, Middle, La: CLAIBORNE WATTS					2. Date of Death	Day y	3. Time of Death
	Examir		4a. Facility Name (If not institution, give MEMORICA)		al	4b. City, Town, o	Location of Death		4c. County of	Death
	Funeral Director		5. Social Security Number 6. S 226-32-2146		(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth Month, Day Y	0	Birthplace (State or Foreign Country) VIRGINIA
	within 72 hours after death with the Maryland ene. than "natural", or Hems 23s or 28s-f show rs Madical Exterior or transfer and the mailined at	tor	Usual Residence of Decedent 10a. State 10b. County MD TAL		10c. City, Town or Lo	ocation II CHAELS				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Director	10e. Street and Number 8753 BOZMAN-NEA			10f. Zip Code	663	10g	. Citizen of Wh	_
	ns 2;	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.			city Yes or No-	14 Bace -	USA American Indian,
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Macical Executive Irrual be notified at ADRE.	by	1 ☐ Never Married	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	tispanic Origin? (Spean, Mexican, Puerto F Specify:	Rican, etc.)		White, etc. WHITE
21215-0036	ithin 72 ho ten "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	g 16	b. Kind of Busin	ness/industry
2	led w lygier har th		12	4	DEV	ELOPER			REAL ES	TATE
and	t be filed ntal Hygie ad othar event, tr	Be	17. Father's Name (First, Middle, Last) CLAIBORNE W. GOO	CII ID			18. Mother's Name		,	
Maryland	should ind Men ind marka umatic	၉	19a. Informant's Name/Relationship (7		19h Mailir	nn Address (Street	and Number or Rural	A CHRIST		ato Tin Code)
	and 2 sealth ar n 27 is		SHIRLEY S. GOOCH				ST. MICHA			are, zip Code)
altimore,	as 1 a of Hec litem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		ate 20	c. Location - Ci	ty or Town, State
<u>E</u>	Pages ment of ant: If its ury or o		1 Burial 2 Cremation 3 `4 Donation 5 Other (Specify		_		ETERY 4-18	-2005 S	т. мтсн	AELS, MD
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	\$88	CCP FE	2. Name and Addre		& NEWNAM	FUNERA	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. NOUS	e death. Do not ant	ter the mode of dyin	ng, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
	Examiner	e r	Sequentially list conditions, if any, leading to immediate	t	consequence of):					
	le be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c						
68760,	cate be e physician the buria	cal	· · ·	d						
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date o	f delivery Day Year
S, D	n requires that the bean signed by should be detact	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause grv	en in Part I.	23e. Did tobac		ite to the cause of death?
I Record		Completed						24a. Was an autopsy performed	d? prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vital	ysician: This certificate	Be (25. Was case referred to medical examiner?				26. Place of Death			
	Physi this c	2	1 Yes 2 No	Hospital:	2 ER/Outpatien		4 Nursing Hom	e 5 Residenc		Specify)
Division of	Attending Physician: r death. ector: After this certific. by the funeral director.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	'ear) 28b. Time of Injury	Worl	yat k? Yes 2 ∐No	3d. Describe how	injury occurred	
VIS	or Attencater death Director: in by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, str			3f. Location (Stree	at and Number o	or Rural Route Number.
ā	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	al Certification;	29a. Certifier 1 Certifying Ph	building, etc. (ny knowledge, death	occurred at the tim	ne date and place ar	City or Town, S	State)	V or stated
	n 24 h	edical	(Check only 2 Medical Examone)	iner: On the basis of ex and manner states	Cammation and or in	vestigation, in my q	pinion, death occurred	d at the time, date	and place, and	due to the cause(s)
,	To the within 2 To the complet	M	29b. Signature and title of certifier	ur		29c License	e number 3 \$ \$ \$ \$ 7	29d.	Date signed (A	Month, Pay, Year)
الالم	*)		30. Name and address of person who	Smil	U 2	Print)	Wash in	atas <	TEN	21601 MD
1	Sta Registr		31. Date filed (Month, Day Year) 1	3 2805 Registrate	Signature	Boarts .	wysk in	310/1 2	1. 6	DION MIN

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Gooch, Cluberne W. III

	1	For State Registrar	State of		and / Depa		t of H	ealth a		lental Hygi	_	05	1598
		Decedent's Name (First, Middle	, Last)							2. Date of Death	1		3. Time of Death
Physician /Medica		WILLIAM F. GA	NNON							Month APRIL	Day 2 4	Year 2005	8:25 AM
Examine		4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		4b. City,	Town, or	Location of	of Death	1.2.2.2	_	ty of Death	, 0.20
		515 AUGUST ST					EAS	STON				TALBOT	-
Funeral Director		5. Social Security Number 211–20–4060	6.Sex XXM 2□F	7. Age (In y 78	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, JULY 22	1926	9. Birthp Cour MAR	olace (State or Foreigntry) YLAND
3	-	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation						1	Od. Inside City Limit
d a	ō	MD TAL	OUT.		E	ASTON							XXYes 2 N
28a	Funeral Director	10e. Street and Number	501		<u> </u>	10f. Zip	Code			10	g. Citizen o	f What Cour	ntry?
38 0	2	515 AUGUST ST.					216	01				USA	•
ms 2	Jers	11. Marital Status	12. Was Dec	edent Ever in	n U.S. 13.	Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ	
- 1	2	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	Armed F MXYes If Yes, G Year or I	2 □ No ive		1 ⊡ Yes :		Specify:	, Риепо	Hican, etc.)	Spec	ack, White, ify: W	etc. HITE
lical	Completed	15. Decedent	s Education	· · · · · · · · · · · · · · · · · · ·	16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of work	ina	6b. Kind of	Business/In-	dustry
Men "	ed -	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT us	se retired	iuring mosi)	t or work	ing			
Hygien ther th int, the	5	11	Ö		TUA	O BOD	Y RĘ	PAIR			A	UTO	
d oth	Re	17. Father's Name (First, Middle, L								e (First, Middle, N		ame)	
arka	0	WILLIAM C. GAI	NON					ED	AM	MAE WILSO	ON		
27 Is m ar traum		19a. Informant's Name/Relationsh M. CATHERINE GA		'E		-				al Route Number, DN, MD 2.		n, State, Zip	Code)
ant: If itam 27 I		20a. Method of Disposition 1		State	cemetery, cre	matory or o	ther plac	1			20c. Location		
crtant: If injury or a.	1	 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L 			SPRING H	ILL C 2. Name an				9-2005	EASTO	MA. MA	RYLAND
Important: ary injury or a.		Joseph m. C	Istronli'		$A \qquad \stackrel{\mathbf{F}}{\underset{2}{{{}{}{}{}{}$	ELLOW	S, H HAR	ELFEN	BEIN ST	N & NEWNA	MD 21	ERAL 1	HOME PA
	cal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a cons	sequence of): sequence of):	ear	(Cl						Injerval Between Onset and Death
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□F nant at time (etal death 3	∃Ectopic pr ∃ Other (sp						Pate of deliver	ery Day Year
pe pe	o D	Part II. Dther significent conditio	ns contributing to	death but not	resulting in the u	inderlying c	ause give	en in Part I.			acco use co s 2 🕒 No		ne cause of death?
age 2	Completed							-		24a. Was ar autops perform 1 Yes 2	/	were auto prior to co death? 1 Yes	psy findings availab mpletion of cause o
ill o	Be	25. Was case referred to medical						26. Place	of Deat	h Check on one			
S D	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	P ☐ ER/Outpatie	nt 3 DC	A Oth	er: 4 🗌 Nu	irsing Ho	me 5 X Reside	nce 6 🗆 O	ther (Specif	y)
	ertification:	27. Mann of Death 1 watural 5 ☐ Pending 2 ☐ Accident investig	ation	of Injury oth, Day Year	28b. Time of Injury	M 2	8c. Injun Worl	at at		28d. Describe ho			
al Diractor: ad in by the	Certific	3 Suicide 6 Could n 4 Homicide determi	ned 286. Plac	e of Injury - A ling, etc. (Spe	at home, farm, st ecify)	reet, factory	, office			28f. Location (Str City or Town		nber or Rura	d Route Number,
To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examiner: On the I and mar	e best of my basis of exam nner stated.	knowledge, deat nination and/or in	h occurred ivestigation	at the tim , in my of	ne, date an pinion, dea	d place, th occur	and due to the ca red at the time, da	use(s) and rate and place	nanner as s a, and due to	tated. the cause(s)
Tot	M	29b. Signature and title of certifier	Sm	12		290	License	number GTS	7	29	od. Date sign	25/C	Day, Year)
-11/1		30. Name and address of person of DAVID SMITH M.				,	TON.	MD 2	2160	1	2		
State Registra	-	31. Date filed (Month, Day, Year) APR 2 7 28	<i>3</i> 2.	Registrar's Si		****	,						
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ORIGINAL

			4 101	partment of Health and Mertificate of Death		711115	15082
			Decedent's Name (First, Middle, Last)	oranoato or Beatin	Reg. 2. Date of Death	No.	3. Time of Death
I	Physici		Hilda Agnes Greer		April 30	Day Year	5:55 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	IIP I I I	4c. County of Death	3.33
	LAGITIT		St. Mary's Nursing Center	Leonardtown		St. Mary	's
	Funeral		Social Security Number		8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		577-14-3196 1□ M 2⊠ F 86 Yrs.	Months Days Hours Min.	October 8,	1918 Was	ington, DC
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			
	eho	ក	Maryland St. Mary's Hollyw				0d. Inside City Limits 1 ☐ Yes 2 전 No
	28a-f	Director	10e. Street and Number	10f. Zip Code	10-	Civi	
	with with	٥	24445 Morgan Rd.	20636	Tog.	Citizen of What Cour USA	itry?
	leath	Funeral	The state of the s		ecity Yes or No-	14. Race - Americ	ean Indian
	fler d	ᇤ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White,	
ğ	al', o	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or llems 23a or 28a-f ehow event, I'n Medical Evarries must be notified at	Completed	15. Decedent's Education 16a. Decedent's racio completed) (Gi	cedent's Usual Occupation	165	. Kind of Business/In	dustry
2	filed within Hygiene. wher then "	npie	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working. DO NOT use retired)	9		
2	filed withi Hygiene. other than	CO		lomemaker		Own Home	
and		Be	17. Father's Name (First, Middle, Last) James Edward Grinder	18. Mother's Name Beulah	(First, Middle, Mail Robey	den Surname)	
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Mary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic			iiling Address <i>(Street and Number or Rur</i> a 4404 Morgan Rd. Ho			(Code)
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			23a. Part . Enter the disease, or complications that caused the death. Do not e	P.O. Box 270 Leonar enter the mode of dying, such as cardiac o		20650	Approximate
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	nysic nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3☐ DOA Other: 4€ Nursing Hor	me 5 Residence	6 Other (Specif	y)
0	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time Injury		28d. Describe how i	njury occurred	
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Division of		ertification:	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	i Route Number,
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	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) 22 Medicel Examiner: On the basis of examination and/or and/or and/one)	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day Year)
	⊢ s ⊢ ŏ		by mart barrow	1 106419	7	5-2-6	3
1	om		30. Name and address of person who completed gause of death (Item 23a) (Type	pe, Print)			
7	7 N	1		Notch Road, Hollywo	od, MD 2	0636	
	Sta		31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	4			
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ISAAC J. CORMAN APRIL 2005ear 26, 9:57 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONIGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July31, 1914 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 ☐ F 057-05-9351 Yrs. 90 Director New York Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: if itam 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Emotified at appre 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 ☐ Yes 2√2 No 10e. Street and Number 1111 University Blvd., W., #717 10g. Citizen of What Country? United States 10f. Zip Code 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by Specify: 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Patent Examiner U.S. Government 12 1 - 417. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Gorman Allegra Cassuto ပ္ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Gorman -son 3897 Maryland Manor Dr. Monrovia, Maryland 21770 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Mount Lebanon Cemetery 4/28/2005 Adelphi, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europa Servi Licensee Donald V. Borgwardt Funeral Home, PA Care 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Cerebrovascular Accident 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the burial-Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 2 🔀 No 1 Tes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ٩ 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a Example 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D60826 Kindura Cra April 26, 2005 Oj 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, M.D. 1500 Forest Glen Rd. Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) APR 27 Registrar's Signature State 2005 Registrar

			T = For State Registrar	State of Marylan		artment of H			jiene	15981
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last RANCE 2 4a. Fecility Name (If not institution, give	>	JEF	DER	or Location of Dea	2. Date of Dea Month		
	Funeral Director		Manor Care Nu 5. Social Security Number 6. Se 579-28-7475 Usual Residence of Decedent		last birthday) Yrs.	If Under 1 Year Months Days	Silver Sp If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day	year) 9. Bir	gomery thplace (State or Foreign ountry) th Carolina
	within 72 hours after death with the Maryland ene. then "nature!, or Itams 23s or 28s-f show the Modical Examiner must be notified at	Director	10a. State 10b. County Maryland Prince 10e. Street and Number	George's	y, Town or Lo		shingtor		0g. Citizen of What C	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itams 23s or 28a-f show may injury or other traumatic event, the Mucical Examiner must be notified at ance.	by Funeral Director	11610 Hickory Dr 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forcee? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Bleck, Wai	d States erican Indian, Prefican merican
21215-0036	filed within 72 ho Hygiene. other then "natur. ent, the Madical!	Completed	15. Decedent's Ed. (Specify only highest grade Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Laborator	during most of wo	cian	16b. Kind of Business Gover	
Maryland	should be fit and Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) Lewis Wa 19a. Informant's Name/Relationship (T)		10b Mailie	an Address (Street			Maiden Sumame) Chapman r, City or Town, State,	Tin Code)
	s 1 and 2 s if Health an itam 27 is i		Marisa Milton -	Granddaughter	lace of Disno		h St., N	.E. #2,	Wash., DC 20c. Location - City or	20002
Baltimore,	permit. Pages Department of I Important: If its any injury or o once.		1 🖺 Burial 2 Cremation 3 F 4 Donation, 5 Other (Specify) 21. Signiture of Funeral Service Licen	Ant	cioch l	Baptist (2. Name and Addre	Ch. 4/3		Prosperuneral Home	
13.63	Physician /Medical		23a. Pa 1 Enter the disease, or comp show, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the death	EUW					Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	licai Examiner	Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	Duence of):	STAG W SOI	E S	DEM	ENTTA	
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	death 3	Ectopic pregnancy	у		23d. Date of de Month	livery Day Year
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tal Rec	Physician: The law r this certificate has b ral director, page 2 si	e Completed	25. Was case referred to medical				Of Place of Do		ned? prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	Attending Physician: It death. ector: After this certifics by the funeral director.	To B	examiner? 1 Yes 2 No 27. Manner & Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpati	ER/Outpatier 28b. Time of Injury	28c. Injur	ner: 4 Charsing F		ence 6 Other (Spe	city)
Divis	in the se	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify	′)			City or Town		
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 □ Certifying Phy 2 □ Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, deatl tion and/or in	n occurred at the tirvestigation, in my o	ppinion, death occi	urred at the time, d	ause(s) and manner as ate and place, and due	o to the cause(s)
8	(in)		30. Name and address of person who co	ompleted cause if death (Item	23a) (Type.	I	003	38521	ARRIL	26 2005
) Kall	Sta Registr		SHTUAN C 31. Date filed (Month, Day, Year) APR 2 8 2005	O STIVE Registrar's Signa	TATS		PERMA	NENTE	ROCHI	DIF MD

I or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 Division of Vital Records, P.O. filled in by

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2005 16 HELEN G. HARRISON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PASTON Memorial ITa If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) AUG 31 1927 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Davs 1 □ M 2X F Months MARYLAND 77 Director 218-20-9334 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD TALBOT BOZMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 7798 QUAKER NECK ROAD 21612 USA Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2☐XNo Yes, Give 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 √Widowed 4 ☐ Divorced Year or Dates 'neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental PAUL L. GARRETT BESSIE SPENCER ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Just 1 and Just 1 and Just 1 and Just 1 is Important: If item 27 is any injury or other once. 200 BEECHWOOD AVE #19 DOVER, DE 19901 OLEY W. HARRISON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🛮 Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) WHITEMARSH CEMETERY 4-20-2005 TRAPPE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN K 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart taslure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End stage Renal disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic obstruetne 3 ☐ Probably 4 ☑ Inknown pulmona 1 ☐ Yes 2 ☐ No discose 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? France renal insufficien 2 🗆 No 1 Yes 2 No 1 Yes 25. Was c se referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L Hospite 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Harou Laura 55484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON MD 21601 Nashington ST. aura 32. Segistrar's Signature 31. Date filed (Month Pay. 9 State Registrar

		State of Maryland / D	Department of Health and No Certificate of Death	•	ne 2005	15986
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/Med	dical		RNEY	April 2	1 2005	7:55 P M
Exam	niner	4a. Facility Name (If not institution, give street and number) 8794 Black Dog Alley	4b. City, Town, or Location of Death Easton		4c. County of Deat Tall	
Funera Directo		5. Social Security Number 217-30-8544 6. Sex 1 M 2 F 7. Age (In yrs. last birth production)	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye Mar. 22,		hplace (State or Foreign untry) yland
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
ne Maryli 8e-f sho	ector	MD Talbot	Easton			1 ☐ Yes 2 🛣 No
with th	Funeral Director	10e. Street and Number 8794 Black Dog Alley	10f. Zip Code 21601		Citizen of What Co nited St	•
death	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame	rican Indian,
ified within 72 hours after death with the Maryland Hygiene. Hygiene they net then neturel; or Items 23e or 28e-f show ont, it is Medical Examinar must be notified at	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	1 ☐ Yes ŽŒNo Specify:	o Hican, etc.)	Specify: White	
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Page tment tent: It			ShoreVA Cem. 4/25	/2005 Hu	rlock, l	Maryland
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is	g	21. Signature of Funeral Service Licensee William J. Esbar	22. Name and Address of Facility Fr 216 North Main s	t. reder	uneral] alsburg	Home, PA , MD 21632
Physicia	n	23a. Part1. El ter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medica	al	resulting in death) a. Due to (or as a consequence of	Cancer on: tructure pulmonar, on:			570011
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uted	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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leath certifica attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant in the cost 1/2 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deli	very
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l or Attendati after deati Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St		ral Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, I	edical C	29a. Certifier (Chack only one) Chack only one) Certifying Physician: To the best of my knowledge and manner stated.	, death occurred at the time, date and place, Yor investigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comple	₹	29b. Signature and title of certifier	29c. License number	29d. i	Date signed (Month	
		de Mo	00051132		4-25-	25
		30. Name and address of person who completed cause of death (Item 23a) (\$\int ABLEGO 598 Cunwood \text{DR}\$	Type, Print) Easton, Md. 2169			
S	State	31. Date filed (Month Party 2015 2015 32. Resistrar's Signature				
Regis	strar	2 2 2003	And i			

				epartment of Health and Men Certificate of Death	ntal Hygier Reg. N	711115 15007
ı	Physici		1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death 3 2005 0844 AM
	/Medic Examin		4a. Pacify Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthon 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. 8, 0 Months Days Hours Min. Art Min. Art Min. Art Min. Art Min. Art Min.	Dat of Birth (Month) Day, Yea pril 21.	y. Birthplace (State or Foreign Country) 2005 Maryland
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920	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28e-f show Medical Esantiner must be rollified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☑ No Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	E . E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of working le. DO NOT use retired)		Kind of Business/Industry
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Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licenster	Resthavenes Fulleral Ser 9501 Catoctin Mtn. Hw	rvices, wy. Fred	Skkot Cody P.A.
			23a. Days. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset and Death
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	cate be executed physician and the burial-transit	I Examiner		₹ √	rom€	32 hours
O. Box 68760,	death certifi e attending I od for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	T'	23d. Date of delivery Month Day Year
rds, P	The law requires that the the has been signed by thoage 2 should be detache	by	Part II. Other significant conditions continuing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Record		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1
Vital	Physicien; rthis certific ral director,	o Be	examiner?	26. Place of Death (C) atient 3 DOA Other: 4 Nursing Home		6 ☐Other (Specify)
on of	ing After une	tion: T		ne of 28c. Injury at 28d.	. Describe how in	
Division	or Attention death irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospite 4 hours Funerel ely filled	edical C		feath occurred at the time, date and place, and or investigation, in my opinion, death occurred a	due to the cause at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 7 127//	29d. [Date signed (Month, Day, Year)
•			30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, Print)	Aps	11 25, 2005
			Richard Telescomb 22 S. Gree	(1)	e MD	21201
	Sta Regist		31. Date filed (Month, Pay, Year) APR 2 8 2005 32. Refistrar's Signature	April 1		

State of Maryland / Department of Health and Mental Hygiene For State Amended #12 Per FH; FCHD Registrar tm Certificate of Death04/28/05 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** :10P. M DRIL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** PEDERIUL nder 1 Year | If Under 24 Hrs. FREDERICK MANGR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 76 Days Hours Min. 12M 20 F 212-24-6803 FREDERS LE MO Director 20 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show eny injury or other treumatic avent, the Medical Examinar must be neutried at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 12 Yes 2 No FREDERICK M FREDERICK Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.SA 316 21701 12 Was Decedent Ever in U.S. Armed Forces? 4 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 WAMRIS TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RENE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/ ELLROSE COURT FREBERICK MS. 21703 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5-3-2005 FREDERICK MB FAIRNEW CEM. ^¹ 4 □Donation 5 □Other (Specify) ROLLING FUNERALHONE 22. Name and Address of Facility GARY 21. Signature of Funeral Service Licensee Jouth ST FREDERICK MA. 10 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 400 Gallin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physicien and ched for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 2√ No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: P 1 ☐ Yes 2 ☐No 1 Inpatient All Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem-23a) (Type, Print) LINE 300 w. MEDERUIK mit. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 8 Registrar

			1- State of Maryland / Dep	artment of Health and M		711115	15080
	Physici		Decedent's Name (First, Middle, Last)	Timodio of Bodin	Reg. 2. Date of Death Month		3. Time of Death
	/Medic		RONALD VICTOR A. HUE			21, 2005	
	Examin	er	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4c. County of Deat	GOMERY
	Funeral Director		5. Social Security Number 267-85-8500 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 5, 1	9. Birtl 957 Ja	hplace (State or Foreign unity) AMaica
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show amy injury or other traumatic svent, the Madical Exercitien must be notified a once.	Funeral Director	10e. Street and Number 10204 Ridgeline Drive	10f. Zip Code 20886	10g.	Citizen of What Co	•
	r death	inera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
2-0036	ours afte al', or It Exection	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 🏂 ☐ No Specify:		Specify: As	
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פ	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	_	(First, Middle, Maid		
yıand	Menta Menta Marked Marked	To E	Ronald V. Hue		I. Chin		
Mar	nd 2 sh alth and 27 ls m r traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mail Racquel Lawson-Hue (Wife) 102	ng Address <i>(Street and Number or Rum</i> 04 Ridgeline Dr	Al Route Number, Ci	ity or Town, State, Z gomery \	^{Tip Code)} 20886 71g, MD
saitimore,	of Hez		20a. Method of Disposition 20b. Place of Disposition cometery, cre	matory or other place)	The second second	. Location - City or	
Ě	t. Pag tment tent: I		'4 □Donagen 5 □ Other (Specify) Red Hil	ls Cemetery 5/8			
ga	Deparing Department of the poor of the poo			2. Name and Address of Facility SN 246 N. Wash. St.			
			23a. Part 1. Enter the disease, or complications that caused the death. So not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Chath
ŀ.	Physician /Medical		Immediate Cause (Final/disease or condition resulting in death)	14Thm19			5.6(2)
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ō	ing ph	70	IF FEMALE:				
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j.	that the de ed by the detached	Physician/Me	1 Yes 2 No 4 Pregnant at time or death 5t 9 Unknown 9 Unknown	Other (specify)			
<u>છે</u>	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to	. /
ecords,	v requires been sign should be	Completed			1 Tyes		bably 4 Denknown
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	ian: artifical ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☐ 1 (Check only one)	No 1 □ Yes	2 No
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0	ding f th. : After : funer	tion	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
DIVISION	To the Hospital or Attending Pl within 24 hours attendeath. To the Funeral Director: After completely filled in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Ruitate)	ral Route Number,
ם	pital c		29a. Certifier 11 Certifying Physicien: To the best of my knowledge, deal				
	ne Hos n 24 h ne Fun detely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the vithin To the comp	M	29b. Signature and title of certifier	29c. License number	-	Date signed (Month	, Day, Year)
	10			03884	/	14/21/	05
			30. Name and address of person who completed cause of death (Item 23a) (Type, David Kline, M.D. 9901 Medica	l Center Dr., I	Rockvill	e, MD 20	0850
	Sta		31. Date filed (Month, Day, Year) APR 2 7 2005 Registrar's Signature				
	Registr	ar	APR 4 (CUUD) BANGES SO POPUL				

		•	1 - State of Maryl State of Maryl	•	artment of He		ntal Hygie	2005	15990
			Decedent's Name (First, Middle, Last)			2	. Date of Death		3. Time of Death
	Physicia /Medic		Jane Johnson					Day Year 25 2005	3:09 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	•	4c. County of Dea	ath
			Southern Maryland Hospita			inton			George's
	Funeral		1 □ M 2 💢 F	yrs. last birthday) Yrs.		Hours Min.	. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)
	Director		577-66-3950 Usual Residence of Decedent	59			an. 24,	1946 W	Wash., DC
	yland yland		10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e-f st	ctor	DC		Wash	ington			1 TXYes 2 □ No
	th the)ire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
	ath w 23e	Funeral Director	2617 Douglas Road, S.I			20020		United	
	er de	nue	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specit Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: F	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23e or 28e-f show ont, I've Medical Exar, a wir must be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occupation	on	161	o. Kind of Business	s/Industry
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Уa	should be and Mental le marked o	၉							
Mar	12 sh h and 7 le n treun		19a. Informant's Name/Relationship (Type, Print)		ng Address <i>(Street and</i> 17 Douglas				
	Health Health tem 27 I		Pamela Johnson - Daughter 20a. Method of Disposition 20	b. Place of Dispo	sition (Name of	Dat		wash. Location - City o	
Baltimore,	8 + P	- 3	1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crei	matory or other place)	l			
ij	nit. Pa partmen cortant: injury ie.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Journal Service Licensee		et Cemeter Name and Address			Wash., D neral Hom	
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			23a. Part . Enter the disease, or complications that caused the	death. Do not ent					Approximate Interval Between
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	and trans	Examiner	that initiated events						
60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Due to (or as a con	sequence oi):					
8760,	cate physi	dical	d						
9 x	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre	agnancy				23d. Date of de	sliverv
Вох	atter 1 for u	ciar	250. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time		∃Ectopic pregnancy ∃ Other (specify)			Month	Day Year
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	ding Phys Ther this funeral di	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Yea	r) 28b. Time o	Work?	at 286 es 2 □ No	d. Describe how	injury occurred	
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	h occurred at the time,	, date and place, and	d due to the caus	e(s) and manner a	s stated.
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or in	vestigation, in my opir	nion, death occurred	at the time, date	and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of Carthier		29c. License r		29d.	Date signed (Mon	th, Day, Year)
•			Marmin mo		000	55120	/	tpn/ 26 2	1005
R_	(2)		30. Name and address of person who completed cause of death Richard Pilmer my 1328 South	em Aven	Print) und SE Junk		hinghond	De 2003	2
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		1 - For State Registrar	State of Maryland / Dep		•	2005 15991
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, La Do ug la 4 4a. Facility Name (If not institution, giv Anne Ar undel	st) A Kolb, e street and number)	4b. City, Town, or Location of Dea	2. Date of Death Month D	year 3. Time of Death 2 05 8:00 PM
Funera Directo			F 7. Age (In yrs. last birthday	Annapolis If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	Anne Arundel 9. Birthplace (State or Foreign Country) Washington, DC
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Expirither must be notified at	ector	10a. State 10b. County Maryland Anne Anne Anne Anne Anne Anne Anne An	rundel 10c. City, Town or L	cale	100.0	10d. Inside City Limits 1 ☐ Yes 2 No Citizen of What Country?
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21215-0036 de within 72 hours aff giene. er than "natural", or the Wedleal Exam.	ompiete	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12th	College (1-4or 5+) (Giv.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) S & Info. Speciali	prking	Kind of Business/Industry Dep't. of Defense
Maryland 2 d 2 should be filled th and Mental Hygi t? Is marked other traumatic svent,	To Be C	17. Father's Name (First, Middle, Last, Douglas A. Ko.	lb, Sr.	18. Mother's Na Fann	me (First, Middle, Maide nie E. Cante	on Surname) PY
re, Mar 1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (Joan Mary Kolb/ V 20a. Method of Disposition	Vife 5959	ling Address (Street and Number or A Rockhold Creek R position (Name of	d., Deale,	
Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or othe		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Servicer Licer	y) Cedar Hi	1		uitland, MD Las Funeral Home
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	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
f Vital ysician: T is certificate director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Vinpatient 2 ☐ ER/Outpatie	Othor	ath (Check only one)	0 170th-1 (Caratta)
O E = E		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		Home 5 Residence 28d. Describe how inju	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After compiletely filled in by the funeral	i Certification:	3 Suicide 6 Could not b determined	building, etc. (Specify)		City or Town, Star	
To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	sysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and place nvestigation, in my opinion, death occurred	e, and due to the cause(: urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of contifier	ner MD	29c. License number 0059173		ate signed (Month, Day, Year)
		30. Name and address of person who Kalllen	completed cause of death (Item 23a) (Type Kemmer, 900 I)	sestgate fd #3	200, Annay	polis, MD 21401
S Regis	ate	31. Date filed (Month, Day, Year) ADD 2.5 21	ogiotiai o oigitatoro	1	,	

State of Maryland / Department of Health and Mental Hygiene. UU 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY MANOR CARE OF SILVER SPRING SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days Min. Months 1 ☐ M **XX**F SOUTH CAROLINA Director 84 FEB. 11, 1921 248 50 5845 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner outst be notified at XX Yes 2 No Directo WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES NORTHEAST 20002 14 BRYANT STREET, Funerai Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2013 No If Yes, Give Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 Yes XX No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK ģ XX Widowed 4 Divorced Year or Dates: "nstural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 7 is marked other than treumatic event, it s M. College (1-4or 5+) HOUSE KEEPER PRIVATE 7TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HELEN DAVIS WALTER HANCOCK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i VANESSA McINTOSH / NIECE 9773 TIGER LILLY PATH LAUREL, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 04/25/2005 BRENTWOOD, MD * 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 21. Signature of Furreral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 ans Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner T() HTIW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 2 40 certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Thersing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Director: After this 28a. Date of Injury (Month, Day Yeer) in by the funeral 28c. Injury at Work? 27. Manner ef Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral (1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause SHIVAN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2005

Registrar's Signature

			1 - For State Registrar	State o	f Maryl		artment of H		Mental Hy		75 E-A	
	Physic	ian	Decedent's Name (First, Middle, Last June Madeline LU		 I		rimeate or i	Dodin	2. Date of De Month	Day	Year	3. Time of Death 3
	/Medi Exami		4a. Fecility Name (If not institution, give				4b. City. Town or	r Location of Deat		28, 200		9:12 p. M
	Exami	liei	Gilchrist Center			Care	Baltimon		a r		Balti	Lmore
	Funeral	Г	Social Security Number 6. S			yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth Noarl	9. Birthplace (State or Foreign Country)	
	Director		213-12-7313	□ M 2⊠F	88	Yrs.	World's Days	Hours Mill.		2,1916	Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town or L	ocation					10d. Inside City Limits
کے من	Marylar -f show	ō	Maryland Washi	ngton		Нас	erstown					1⊠Yes 2□No
6	th with the Mar 23a or 28a-f st ust be notified	Director	10e. Street and Number	0			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	th with	aiD	404 Liberty Stre	et			21	L740		USA		
5	r dea	Iner	11. Marital Status	12. Was Dece	edent Ever i	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	specify Yes or No)- 14. Rac	ce - Americ	can Indian,
	36 s after o	Y.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir	/0		1 ☐ Yes 2K No				v: whi	
	72 hour	edb	15. Decedent's Ed	Year or D	ates:	16a Dece	dent's Usual Occupa	ation				
r .	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene tither than "natural", or Items 23a or 28a-f show out, the Modical Exercitmet cust be notified at	Completed by Funerai	(Specify only highest gra	de completed)	L dor E i	(Give	kind of work done of DO NOT use retired	during most of wor f)	rking	16b. Kind of B	usiness/in	austry
1	nd 2127 e filed within al Hygiene. l other than vent, ine My	lo m	12	College (1-40(5+)	cle	rk			retai	l sal	.es
200	nd be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	, Maiden Suman	ne)	
9.	faryland	2	William Earl Bowe						lizabeth			
∞:	ire, Maryland 21215-003 s 1 and 2 should be filed within 72 hours Health and Mental Hygiene tiem 27 is marked other than "natural", other traumatic event. Its Madical Exu		19a. Informant's Name/Relationship (7) Gary L. Lushbaugh	•			ng Address (Street a Chardel					
	ore, Miss 1 and 2 of Health a item 27 is		20a. Method of Disposition	1 - 5011					Date	20c. Location		
	Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐		Jiaia		osition (Name of matory or other place 1 Cemeter					
PRIL	altil		21. Signature of Funeral Service Licen				2. Name and Addres	-				Maryland
21	B P P P P P P P P P P P P P P P P P P P		Sixt /	אאאו	in m		15 E. Wil:					21740
<u></u>			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that cone cause on e	aused the d							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Cox		Live h					Onset and Death
	/Medical Examiner	Н	resulting in death)	Due to	or as a con	sequence of):			//(Jean
	Lxammer	_	Sequentially list conditions,	b								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					- 1	
	6 / 6U, ate be executed bysician and the burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):						
5	ate be ex cate be ex ohysician a	dical E		d.								
(
1	box box beath certifice attending perfect use as	ician/Me	200. Was decedent pregnant	23c. If yes, out 1 ☐ Live b	come of pre		Ectopic pregnancy			23d. Dat	e of delive	iry
2 (ne death the atte	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		ant at time o		Other (specify)			Мо	nth	Day Year
3 6	a of	Physi	Part II. Other significant conditions co	intributing to de	ath but not	reculting in the w	adorhina sausa suus	a in Dart I	Die Die L			e cause of death?
17	8 ig 8	d by	De sbetes in	ellil	Tus.	rosalinig in the u	idenying cause give	milir galt j	1 🗆 1	L		ably 4 □Unknown
	> 40	lete	He perten	11100					-			
CHE	The law The has b age 2 sl	Completed	-117 per 1000						24a. Was autop perfo	an 240. V sy rmed?	vere autor prior to cor leath?	psy findings available appletion of cause of
3		a)	25. Was case referred to medical					26. Place of Dea		2 No 1	☐ Yes	2 No
_	Or Vital Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 li	npatient 2	ER/Outpatien	t 3 DOA Othe		ome 5 Resid		er (Specify	Hospica
-	_ = _	ü	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of	of Injury h, Day Year	28b. Time of Injury	28c. Injury Work			now injury occurr		11103716
5	Attending r death. octor: Atten	catio	2 Accident investigation			, ,,,,,		′es 2□No				
3	In by the function	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildir	of Injury - A ng, etc. <i>(Spe</i>	t home, farm, str ecify)	et, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rura	Route Number,
	Hospital 24 hours a Funeral I tely tilled		29a. Certifier 1 Certifying Phy	eician: To the	haet of my l	kanuladan da ath	and the state of t	- 4-44 -1				1
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely tilled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	ner: On the ba	isis of exam	ination and/or inv	estigation, in my op	e, date and place, inion, death occur	red at the time,	cause(s) and ma date and place, a	nner as sta und due to	ated. the cause(s)
	Vithin 2 To the complet	Me	29b. Signature and title of certifier	,	10		29c. License	number		29d. Date signed	(Month, L	Day, Year)
			M ASh	my la	el.	, and	1)2	5205	-	April	29	2005
^	(11 10		30. Name and address of person who co	omptored cause	of death (em 23a) (Type,	Print)	les St	0	7	1 -	
0	H-10		W. H. Kiley	1063	MC	6701	M. Cha	les J/	Bol	To Mo	1 5	120x
	Sta Registr		31. Date filed (Months Pays Year) 2 2	2005 32. Re	fistrar's Sig	gnature A	Cart 1					

		1 - For State Registrar	State of Marylar	•	artment of rtificate of		Mental I	Hygiene Reg. No	2000	15991	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last, Eduardo 4a. Facility Name (If not institution, give)	S.	Maxi		or Location of Dea	2. Date of Month April 2	6, 200°	y Year	3. Time of Death 11:54 A	
Funeral Director		Ft. Washington Hospita 5. Social Security Number 6. Se.	1	. last birthday) Yrs.	Fort Was	nington	8. Date of	Birth Day, Year)	rince Geo		
D		Usual Residence of Decedent 10a. State Maryland 10b. County Prince Geor	•	ity, Town or Lo				۵/) ۵	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits 1 ☐ Yes 2⁄2 No	
th with the 23s or 28s	Funeral Director	10e. Street and Number 12800 Livingston Road			10f. Zip Code 20744			10g. Cit USA	tizen of What Co	L ountry?	
ours after dea ral', or Items Examination	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Maria Data	67	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: F		
Intimore, Interpretation Z I Z 13-0030 Int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenin of Health and Mental Hygiene. Artenia: If them Z is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event. If a Nexteral Example 1 interpretation is intitied at a second injury or other traumatic event.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire ed States 1	during most of wo	orking	16b. K	p. Kind of Business/Industry Military		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event. It was	To Be C	17. Father's Name (First, Middle, Last) Benjamin Maximo	Grant Crist	100 140			sca Sant	os			
es 1 and 2 st of Health and I Item 27 Is n r other traun		19a. Informant's Name/Relationship (7) Christie Maximo / Wif	e 20b.	12800		on Road For		ton, N		20744	
permit. Pages 1 and: Department of Health Important: If Item 27 any injury or other tr		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Veral Service Licens	Kal	as Crema 22	tory ?. Name and Addr	May ess of Facility G	eorge P.	Kalas	water, Ma Funeral H	lome P.A.	
Physician /Medical		23a. Part1 E fer the disease, or complete shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)		ith. Do not ent				y arrest,	and 2074	Approximate Interval Between Onset and Death	
certificate be executed by the continuation and continuation and continuation are as the burial-transit continuation continuation continuation.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a))).								
death certifi e attending i id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	cy			23d. Date of del Month	ivery Day Year	
requires that the een signed by th hould be detache	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.				the cause of death?	
The lar ate has page 2	Completed						24a. W ai po 1 🗆 Ye	utopsy erformed?	prior to death?	topsy findings available completion of cause of 2 \square No	
Physician: r this certific ral director,) Be	25. Was case referred to medical examiner? 1 XX es 2 □ No	lospital:	3-CD/O	01	26. Place of De			. 504		
A SE	atlon: To	27. Manner of Death 1 文献atural 5 □ Pending 2 □ Accident investigation	1 ☐ Inpatient 25 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Nursing r	28d. Descri		6 □Other (Specify occurred	эпу)	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Certification:	3 Suicide 6 Could not be determined	omicide determined building, etc. (Specify)						9)	ral Route Number,	
he Hosp in 24 hou he Fune pletely fii	edical	(Check only 2 Medical Exemi	sicien: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occ	e, and due to t urred at the tin	he cause(s) ne, date and) and manner as d place, and due	stated. to the cause(s)	
To t To t	×	29b. Signature and title of certifier	pte		29c. Licen	se number			te signed (Montil 27, 2005		
- (5)		30. Name and address of person who co Kenneth Goldstein	ompleted cause of death (Ite MD 2141 K Stree			D.C. 200	037				
St	atė	31. Date filed (Month, Day, Year) APR 2 8 2005	32. Registrar's Sign	ature	E)						

			_ FOI	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2005
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year APRIL 23 2005 8:45PM M
	/Medic Examin		FLORENCE IRENE MILLEMAN 4a. Facility Name (If not institution, give street and number) 5550 BETHLEHEM ROAD	4b. City, Town, or Location of Death PRESTON 4c. County of Death CAROLINE
I	Funeral Director		5. Social Security Number 213-14-1708 6. Sex 1 M 2 M F 81 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day Year) FEB 7 1 924 9. Birthplace (State or Foreign MARYLAND)
	Aaryland f ehow	or	Usual Residence of Decedent	_ocation 10d. inside City Limits RESTON 1 ☐ Yes XX No
	death with the Maryland ms 23e or 28a-f ehow r maat be notified at	Funeral Director	10e. Street and Number 5550 BETHLEHEM ROAD	10f. Zip Code 10g. Citizen of What Country? 21655 USA
		by Funera		. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE
70-6171	filed within 72 hours after Hygiene. other than "natural", or lite ent, the Medical Extention	Completed	(Specify only highest grade completed) (Git Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) HINE OPERATOR FUSE PLANT
	2 should be filed in and Mental Hygie Is marked other reumatic event, it	To Be Co	17. Father's Name (First, Middle, Last) JAMES FREDERICK FAULKNER	18. Mother's Name (First, Middle, Maiden Sumame) MARY DONNELLY
Mar	and 2 sho selth and ! n 27 is ma			iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 BETHLEHEM ROAD, PRESTON, MD 21655
anmore	Pages 1 a ent of Hee nt: if item ry or othe		1 LXBurial 2 Cremation 3 Removal from State	position (Name of ematory or other place) ER CEMETERY 4-28-2005 PRESTON, MARYLAND
סמונו	permit. Pages Depertment of the importent: if ite any injury or of once.		21 Signature of Funeral Service Licensee	22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Approximate Interval Between Onset and Death Aptroxy Approximate Interval Between Onset and Death Ventor V
,00/0	certificate be executed adding physician and use as the burial-transit	dicai Examine	Cause (Disease or injury that initiated events resulting in death) Last C	
ă	death certif e attending id for use a	Physician/Me		□Ectopic pregnancy 23d. Date of delivery Month Day Year
ecords, P	requires that the een signed by th hould be detache	by	Part II. Dther significant conditions contributing to death but not resulting in the Congestive heart Fair	1 Yes 2 No 3 Probably 4 Unknown
vitai Rec	The larate has	e Completed	25. Was case referred to medical	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one)
10 1	ng Phy Iter this neral d	To B	examiner? 1 Yes 2 No 27. Manny of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 2 ER/Outpat 28a. Date of Injury (Month. Day Year) 28b. Time (Month. Day Year)	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28c. Injury at 28d. Describe how injury occurred
DIVISION	To the Hospitei or Attending Ph within 24 hours efter death. To the Funerei Director. After th completely filled in by the funeral	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Town, State)
	the Hosp in 24 hou the Fune ipletely fil	Medical	(Check only one) 2 Medical Examinar: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
	Viit To	-	29b. Signature and title of certifier Aures Succes 45	D31376 4-25-05
			30. Name and address of person who completed cause of death (Item 23a) (Typ James Sides 920 Market	St Deuton 42 21629
	Sta Registi		31. Date filed (Month, Day, Year), APR 2 6 2005	

			1 - State Registrar				,	Cei	rtificate of	Dea	th		Reg. N	.20	05	15	996
Ī	Physici	an	Decedent's Name (First)	, Middle, La	st)							2. Date of De Month	ath Da	ay ,	Year	3. Time of	
	/Medic	cal	WILLIAM S. 4a. Facility Name (If not in:			mborl			4b. City, Town,		on of Dooth	04	_/		1005	180) M
	Examin	ner	THE IN	Stitution, giv	e street and nu	Un.	(PITI	21	40. City, 10wn,	J <	TO A	4c. County of Death			BOT	7	
Ī	Funeral		5. Social Security Number 220–12–0215	6. S	N 2□F	7. Age	(In yrs. last bi		If Under 1 Year Months Days		der 24 Hrs.	8. Date of Bir (Month, Da	th ay, Year)	Coun		or Foreign
	Director	ļ	Usual Residence of Deced		A		82	Yrs.				FEB. 9	19:	23	MAR	YLAND	
	yland low			County			10c. City, Tow	n or Lo	ocation						10	0d. Inside C	ity Limits
	e-fsh	ctor	MD	TALBO	T			E	CASTON							1 🗌 Yes	XX No
	or 28	Director	10e. Street and Number						10f. Zip Code	016	0.1		10g. C		What Coun	try?	
	s 23e	erai	26255 DAFI	IN RO	AD 12. Was Dec	ndost E	ros in II S	12.5	Mas Donadast of	216		anifu Van or No		US.	e - Americ	an Indian	
220	ges 1 and 2 should be filed within 72 hours atter death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Madical Examinar must be notilised at	by Funerai	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Di		Armed F 1 Yes If Yes, G Year or I	orces? 2 ∑ No ive			Was Decedent of If Yes, specify Cul 1 ☐ Yes 2X No			Rican, etc.)			ck, White, e	etc.	
5	72 hc	eted	15. Do (Specify only	ecedent's Ed highest gra	ducation de completed	1	16a	(Give	dent's Usual Occu	during r	nost of work	ring	16b. I	Kind of B	usiness/Ind	lustry	
4	within ane. then *	Completed	Elementary/Secondary ((0-12)	College (1-4or 5+)		<i>DO NOT</i> use retir RPENTER	9d)				BUIL	DING		
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ō	ould be filed with Mental Hygiene. arked other thar atic event, Ire M	To B	GUSTIF F. N	1IELKE							ВО	NNIE BE	CKN	ER			
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Σ 1	and sealth m 27		MARY JANE N		/WIFE		OOb Bless		255 DAFI	IN E		EASTON,	_				
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0	permit. Departn Importe any inju		1040	R.	MERC	ER	3	FE 20	ELLOWS, I OOS, HAI	HELFI RRISC	ENBEIN ON ST	& NEWN EASTON,	MAI MD	FUNE 216	RAL H 01	OME PA	A
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximat Interval Bet	tween		
	Physician		Immediate Cause (Final disease or condition	95	_ a.		New	20/	ogical	D	econ	fen Sa	fic	27		Onset and	n H
	/Medical Examiner		resulting in death)	(Due to	(or as a	consequence	of):	n	_	t					2	2000
L		er	Sequentially list conditions if any, leading to immedia	s, te	b. Due to	(or as a	consequence	of):	ven	en	na		/.		-	= 7	(41)
	outed id ansit	Examiner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	1	C		Ce	rel	Dem	ul	11	norty	40	ien	ey	340	ens
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0	cate b chysic the b	Medicai		•	d												
٥ ٢	certifi nding use as		IF FEMALE: 23b. Was decedent pregn	ant	23c. If <u>yes</u> , ou								- 1	23d. Da	te of delive	ry	
5	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician	in the past 12 month 1 Yes 2 No 9 Unknown			nant at ti	□Fetal death me of death		JEctopic pregnand ☐ Other (specify)		-						Year
Ļ	that the post of t	0_	Part II. Other significant of	onditions o	contributing to	leath but	not resulting	n the u	nderlying cause g	vən in Pa	art I.	23e. Did	tobacco	use cont	tribute to th	e cause of c	death?
ecolus,	quires an sign	ed by	Corone	m	Art	en	101	SLI	nse	_		1 🗆	Yes 2	No No	3 Proba	abiy 4 □l	Unknown
ב ב ב	law re as bee 2 sho	piet	Atria	O I p	Fibri	las	Gon					24a. Was		24b.	Were autor	osy findings	available
	The ate ha	Completed	Colo	n (Carro	el						perfo	rmed?		death?	2₩No	
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5	nding ath, r: Afte e fune	atior	1 Natural 5 🗆 2 🗀 Accident	Pending investigation		nth, Day	Year)	Injury	W	ork?]Yes 2	! □ No						
JVISION	or Atte	ertification:	3 🗍 Suicide 6 🗍 4 🗍 Homicide	Could not b determined	286. Plac	e of Injur ling, etc.	y - At home, fa (Specify)	arm, str	reet, factory, office			28f. Location (City or To			er or Rurai	Route Num	iber.
_	spitel	O	29a. Certifier 1 🔽 C	ertifying Ph	nysician: To th	e best of	my knowledg	e, deati	h occurred at the	ime, date	and place,	and due to the	cause(s) and ma	anner as st	ated.	
	he Hc in 24 l he Fu pletely	edicai	(Check only 2 M	ledical Exar	niner: On the i	ner state	examination ar	nd/or in	vestigation, in my	opinion,	death occur	red at the time,	date ar	id place,	and due to	the cause(s	ş)
	with To t	Σ	29b. Signature and title of	certifier	ing I) c4	do de	11.5	29c. Licer		er ZOZ	16	29d. Da	- ,	d (Month, L	, .	
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				ATIM	1A PA	THA	K, M.		219 5	out	+ WA	SHINGTO	N ST	, E	ASTON	MD	21601
	Sta Registr		31. Date filed (Month, Day	182	805	gistrar	's Signature	Á	Contraction .								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4 13 2005 6:50a Antoinette Assa Madert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner st. Talbot 109 W. Maple Ave. Michaels If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 20 F Yrs. Director 577-12-1534 85 10-1-1919 Washington, DC Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10b County ?7 is marked other than "natural", or Items 23s or 28e-1 show traumatic event, the Madical Examiner must be notified at Md Talbot St. Michaels 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21663 USA 109 W. Maple Ave. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 by If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Manager years 12 years 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: if Itam 27 is marked other any Injury or other traumetic. 18. Mother's Name (First, Middle, Maiden Sumame) Be Yoneji Inozuwa Henrietta Prehn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Madert, III (son) 109 W. Maple Ave. St. Michaels, Md.21663 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Capitol Crematory 4-14-2005 Dover, De. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility R. Carroll Hurley Funeral HomePC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Md 21663
shock, or heart failure. List only one cause on each ring. val Between et and Death elliterrelated Renal Immediate Cause (Final les grabe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of): abete signed by the attending physicien end d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Vasculor disease Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has ndin 1 Yes 2 No or Attanding Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a

To the Funaral I

completely filled 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier hisaell a . Schell 442581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO 555 Cynwood Dr., Easton, Md. 21663 Schilling, 32 Registrar's Signature 31. Date filed (Manth Ray 1 ear) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 000 Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Year **Physician** William Taylor McKenzie 30 16 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Washington County Hospital <u> Hagerstown</u> 8. Date of Birth (Month, Day, Year) April 7 192 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1[XM 2□F 82 Yrs 1923 217-18-4415 Director Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Exeminer must be notified at 1 ☐ Yes XXNo Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 45 Redwood Drive 21740 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 3/24/46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Mechanic State Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 Ia marked other tt any injury or other traumatic evant, The ODG. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John McKenzie Mary Nies ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cleora J. McKenzie (fwife) 45 Redwood Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Maryland Cedar Lawn Mem Park May 4 2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Stenasis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an ate has t page 2 s autopsy nellitus Deapetes certificate 2 No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 PER/Outpatient 3 DOA 2 1 Tes this 28a. Date of Injury (Month, Day Year) Director: After th 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending 1 Natural 1 Yes 2 No death. investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funaral I 1 🔂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911

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Registrar

31. Date filed /Mo:

Registrar's Signatur

16 3 2005

			State of Maryland / Department of Health and M Certificate of Death		giene leg. No. 2005 1599	19
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year 11:49	
-	/Medic Examin		NANCY MARIE MOONEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	APRIL	4c. County of Death	4
	CXAIIIII		Doctors Community Hospital Lanham		Prince Georges	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	(, Year) Country)	reign
	Director		213-20-2589 To M 269 To The Triangle Tr	July 18	3, 1926 Maryland	
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Li	mits
	e Mar	ctor	MD Prince Georges Bowie		Yes 2]No
	vith th	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Country?	
H.	eath v	eral	16010 Excalibur Rd., #A306 20716-3932 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - American Indian,	
20	s after death with the Marylar , or Items 23a or 28a-f show contret must be notified at	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		
03	72 hours after death w "natural", or Items 23a	d by	②MU Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes ②MU No Specify:		Specify: white	
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212	d within	omo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary		Education	
>> \frac{2}{2}	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural; or Items 23s or 28s-f show event, it a Madical Examinar must be mailfied at event, it a Madical Examinar must be mailfied at	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Surname)	
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	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i> Forrest Michael Mooney (son) 13004 Gordon Ave., Belt			.0
~	1 and Heall em 2 ther				20c. Location - City or Town, State	
M altimore	Pages nent of int: If its iry or o		1 □ Burial 2 🗷 remation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Salisbury Crematory 4/26/2	2005	Salisbury, MD	
alti	permit, Page Department of Important: If any injury or once.		21. Signature of Furbral Service Licensee 22. Name and Address of Facility Holloway Melson Fur			
<u> </u>	88 = 28		103 Linden Ave., Po	ocomoke	City, MD 21851	.00
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	or respiratory arr	rest, Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a	N		
	Examiner		Due to (or as a consequence of): Push rator Failly	e		
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initial departs) Anaxic Encephal	000-11	•	
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	opari	3	
60,	be executed sician and burial-transit		Due to (ut as a consequence of).			
68760,	ificate g physi as the l	Physician/Medical	0.			
Вох	leath certifica attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year	
Э.	e dea the att	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		Month Day Year	
P.O.	that the de ed by the detached		Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death	?
Division of Vital Records,	juires tha n signed and be det	d by		1 □ Y	es 2 No 3 Probably 4 Donkno	own
ō	aw require s been si 2 should b	Completed		24a. Was a autops		able
Re	sician: The law certificate has b irector, page 2 s	mo:		perfor	med? death? 1 Yes 2 No	01
/ita	clan: ertifica ector,	Be	25. Was case referred to medical examiner? 26. Place of Death			
of \	Physic this c	-T	1 Tyes 2 1 No Hospital: 1 Inputient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other (Specify)	
on	ding F th. : Atter s tuner	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Injury M 1 Yes 2 No		,	
Visi.	or Attendi atter death. Director: A in by the tu	ertification:	S C Could not be	28f. Location (Si City or Town	treet and Number or Rural Route Number, n. State)	
ō	ital or A	O	. /		,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours started teath. To the Funeral Director: The the sentilicate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 ☑ Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, a concern of the commo			
_	To the	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month, Day, Year)	
			MOS 60611		4/24/05	
011	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, .		
CA	10		Samuel Asfaw MD 575 MAIN STREE 31. Date filed (Month, Day, Year) 32. Jagistrar's Signature	T LAC	REL, RED JOTE	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2: 7 2005 32. Fegistrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year TOHN **Physician** 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** AA Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 19, 1 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 009- W- 7919 Usual Residence of Decedent 1934 Vermont Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show 10a. State 10b. County ANNAMOZIS M. 1 AA 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 433 126 7 is marked other than "natural", or items 23a traumatic event, the Medical Examinar must t Funeral 12. Was Decedent Ever in U.S. Armee Forces?
1 ™Yes 2 ™No
If Yes, Give
Year or Dates: 1950-1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mantal Hygiene. Important: if item 27 ia marked other than "ne any injury or other traumatic avent and once. Elementary/Secondary (0-12) College (1-4or 5+) hardware store 12 executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leath Wells Harold McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 126 Riverview Ave. Annapolis, MD 21401 Sue McGrath/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4-26-05 Mt. Airy, MD ' 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Euneral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYSCARD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 1 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person pho completed cause of death (Item 23a) (Type, Print) FOREST DRIVE 1616 cont BONTED C. gistrar's Signature State 2005 Registrar